April 7, 2008

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

SUBJECT: Announcement of Calendar Year (CY) 2009 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 2009, and the risk and other factors to be used in adjusting such rates. Attached is a spreadsheet containing the capitation rate tables for CY 2009. 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.

Attachment I shows the final estimates of the increase in the National Per Capita MA Growth Percentage for 2009. As discussed in Attachment I, the final estimate of the increase in the National Per Capita MA Growth Percentage for combined aged and disabled beneficiaries is 4.24 percent. These growth rates will be used as the minimum update percentage in calculating the 2009 rates, except for the ESRD State rates, which are subject to a 2 percent minimum increase under Section 1853(a)(1)(H). The county fee-for-service (FFS) rates for 2009 were rebased. Under section 1853(c)(1) of the Act, MA capitation rates in 2009 will be based on the higher of the county FFS per capita amount or a minimum percent increase over the 2008 rate.

Attachment II provides a set of tables that summarizes many of the key Medicare assumptions used in the calculation of the National Per Capita MA Growth Percentage.

Section 1853(b)(4) of the Act 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 2006 is being posted on the above website at this time as well.

We received comments from 30 organizations in response to CMS' request for comments on the Advance Notice of Methodological Changes for CY 2009 MA Capitation Rates and Part D Payment Policies (Advance Notice), published on February 22, 2008. Six comments were from Associations, 23 comments were from plans, and one comment was from the Congress. Attachment III summarizes key policy changes from the approaches proposed in the Advance Notice , the key policies adopted as proposed in the Advance Notice, and then presents responses to comments on Part C and Part D issues in the Advance Notice. Attachment IV contains tables with the 2009 CMS-HCC risk adjustment factors, Part D benefit parameters, and other information. The CMS-HCC factors are also available in Excel files on the CMS website at http://www.cms.hhs.gov/MedicareAdvtgSpecRateStats/RSD/list.asp#TopOfPage.

Questions can be directed to:

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Attachments

Attachment I. Final Estimate of the Increase in the National Per Capita MA Growth Percentages for 2009

The first table below shows the National Per Capita MA Growth Percentages (NPCMAGP) used to determine the minimum update percentages for 2009. Adjustments of 0.22 percent, 2.07 percent, -11.69 percent and 0.48 percent for aged, disabled, ESRD, and combined aged and disabled, respectively, are included in the NPCMAGP to account for corrections to prior years' estimates as required by section 1853(c)(6)(C). The combined aged and disabled increase is used in the development of the ratebook.

The second table below shows the monthly actuarial value of the Medicare deductible and coinsurance for 2008 and 2009. In addition, for 2009, the actuarial value of deductibles and coinsurance is being shown for non-ESRD only, since the plan bids will not include ESRD benefits in 2009. These data were furnished by the Office of the Actuary.

Increase in the National Per Capita MA Growth Percentages for 2009

	Prior Increases	Current Increases			NPCMAGP for 2009 With Sec.1853(c)(6)(C) adjustment[1]
	2003 to 2008	2003 to 2008	2008 to 2009	2003 to 2009	
Aged	33.78%	34.07%	3.66%	38.97%	3.88%
Disabled	38.10%	40.96%	4.20%	46.87%	6.35%
ESRD[2]	28.99%	13.91%	1.34%	15.44%	- 10.51%[3]
Aged+Disabled	34.24%	34.89%	3.74%	39.94%	4.24%

[1]Current increases for 2003 to 2009 divided by the prior increases for 2003 to 2008.

[2]Starting in 2008, increases for ESRD reflect an estimate of the increase for dialysis-only beneficiaries.

[3]The NPCMAGP for ESRD for 2009 will be the minimum 2 percent increase.

Monthly Actuarial Value of Medicare Deductible and Coinsurance for 2008 and 2009

	2008	2009	Change	2009 non-ESRD
Part A Benefits	36.71	37.94	3.35%	36.35
Part B Benefits[4]	105.69	97.97	- 7.30%	92.30
Total Medicare	142.40	135.91	- 4.56%	128.65

[4]Includes the amounts for outpatient psychiatric charges.

Medical Savings Account (MSA) Plans. The maximum deductible for current law MSA plans for 2009 is $10,500. For MSA demonstration plans, the 2009 minimum deductible amount is $2,200, the maximum out-of-pocket amount is $10,500, and the minimum difference between the deductible and deposit is $1,000.

Attachment II. Key Assumptions and Financial Information

The USPCCs are the basis for the National Per Capita MA Growth Percentages. Attached is a table that compares the published United States Per Capita Costs (USPCC) with current estimates for 2000 to 2009. In addition, this table shows the current projections of the USPCCs through 2011. 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 2011.

All of the information provided in this enclosure applies to the Medicare Part A and Part B programs. Caution should be employed in the use of this information. It is based upon nationwide averages, and local conditions can differ substantially from conditions nationwide.

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

Comparison of Current Estimates of the USPCC with Published Estimates

PART A:

Calendar Year	Aged Current Estimate	Aged Published Estimate	Aged Ratio	Disabled Current Estimate	Disabled Published Estimate	Disabled Ratio	Aged and Disabled Current Estimate	Aged and Disabled Published Estimate	Aged and Disabled Ratio
2000	$263.29	$286.18	1.087	$218.80	$230.48	1.053	$257.32	$278.61	1.083
2001[1]	$283.70	$288.62	1.017	$234.62	$235.50	1.004	$276.94	$281.25	1.016
2001[2]	$283.70	$298.43	1.052	$234.62	$242.00	1.031	$276.94	$290.59	1.049
2002	$297.13	$294.46	0.991	$248.90	$242.06	0.973	$290.30	$287.10	0.989
2003	$304.89	$290.50	0.953	$254.01	$234.89	0.925	$297.41	$282.50	0.950
2004	$321.69	$326.78	1.016	$268.45	$271.69	1.012	$313.59	$318.43	1.015
2005	$344.77	$348.28	1.010	$288.32	$291.45	1.011	$335.90	$339.49	1.011
2006	$354.98	$351.38	0.990	$302.34	$295.15	0.976	$346.55	$342.67	0.989
2007	$369.31	$370.34	1.003	$326.21	$318.17	0.975	$362.38	$362.06	0.999
2008	$395.22	$385.61	0.976	$356.44	$344.31	0.966	$389.02	$379.02	0.974
2009	$414.22	$414.22	1.000	$378.40	$378.40	1.000	$408.50	$408.50	1.000
2010	$430.77			$395.77			$425.13		
2011	$445.76			$412.87			$440.46		

PART B:

Calendar Year	Aged Current Estimate	Aged Published Estimate	Aged Ratio	Disabled Current Estimate	Disabled Published Estimate	Disabled Ratio	Aged and Disabled Current Estimate	Aged and Disabled Published Estimate	Aged and Disabled Ratio
2000	$199.17	$218.78	1.098	$183.62	$195.91	1.067	$197.24	$216.03	1.095
2001[1]	$219.73	$217.57	0.990	$206.93	$191.99	0.928	$218.10	$214.32	0.983
2001[2]	$219.73	$223.83	1.019	$206.93	$198.69	0.960	$218.10	$220.63	1.012
2002	$233.03	$244.17	1.048	$226.37	$218.23	0.964	$232.16	$240.76	1.037
2003	$250.81	$232.24	0.926	$246.76	$211.58	0.857	$250.26	$229.47	0.917
2004	$276.49	$263.39	0.953	$274.60	$252.74	0.920	$276.22	$261.89	0.948
2005	$296.08	$281.90	0.952	$292.35	$272.79	0.933	$295.54	$280.58	0.949
2006	$318.61	$311.28	0.977	$312.22	$316.82	1.015	$317.66	$312.09	0.982
2007	$332.84	$334.02	1.004	$329.40	$343.76	1.044	$332.32	$335.47	1.009
2008	$349.79	$354.44	1.013	$349.43	$343.26	0.982	$349.74	$352.75	1.009
2009	$358.03	$358.03	1.000	$357.10	$357.10	1.000	$357.89	$357.89	1.000
2010	$370.01			$371.74			$370.27		
2011	$381.97			$386.31			$382.63		

PART A & PART B:

Calendar Year	Aged Current Estimate	Aged Published Estimate	Aged Ratio	Disabled Current Estimate	Disabled Published Estimate	Disabled Ratio	Aged and Disabled Current Estimate	Aged and Disabled Published Estimate	Aged and Disabled Ratio
2000	$462.46	$504.96	1.092	$402.42	$426.39	1.060	$454.56	$494.64	1.088
2001[1]	$503.43	$506.19	1.005	$441.55	$427.49	0.968	$495.04	$495.57	1.001
2001[2]	$503.43	$522.26	1.037	$441.55	$440.69	0.998	$495.04	$511.22	1.033
2002	$530.16	$538.63	1.016	$475.27	$460.29	0.968	$522.46	$527.86	1.010
2003	$555.70	$522.74	0.941	$500.77	$446.47	0.892	$547.67	$511.97	0.935
2004	$598.18	$590.17	0.987	$543.05	$524.43	0.966	$589.81	$580.32	0.984
2005	$640.85	$630.18	0.983	$580.67	$564.24	0.972	$631.44	$620.07	0.982
2006	$673.59	$662.66	0.984	$614.56	$611.97	0.996	$664.21	$654.76	0.986
2007	$702.15	$704.36	1.003	$655.61	$661.93	1.010	$694.70	$697.53	1.004
2008	$745.01	$740.05	0.993	$705.87	$687.57	0.974	$738.76	$731.77	0.991
2009	$772.25	$772.25	1.000	$735.50	$735.50	1.000	$766.39	$766.39	1.000
2010	$800.78			$767.51			$795.40		
2011	$827.73			$799.18			$823.09		

[1]Applies to M+C ratebook for January to February, 2001
[2]Applies to M+C ratebook for March to December, 2001

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

PART A:

Calendar Year	ESRD Current Estimate	ESRD Published Estimate	Ratio
2000	$1,311.44	$1,443.13	1.100
2001[1]	$1,424.11	$1,541.76	1.083
2001[2]	$1,424.11	$1,597.34	1.122
2002	$1,459.75	$1,435.62	0.983
2003	$1,570.85	$1,596.58	1.016
2004	$1,682.53	$1,685.25	1.002
2005	$1,589.31	$1,759.90	1.107
2006	$1,635.76	$1,717.97	1.050
2007	$1,687.04	$1,874.54	1.111
2008	$1,812.40	$1,855.03	1.024
2009	$1,911.06	$1,911.06	1.000
2010	$1,996.18		
2011	$2,077.10		

PART B:

Calendar Year	ESRD Current Estimate	ESRD Published Estimate	Ratio
2000	$1,676.80	$2,436.13	1.453
2001[1]	$1,880.19	$1,875.57	0.998
2001[2]	$1,880.19	$1,921.53	1.022
2002	$1,995.37	$2,014.79	1.010
2003	$2,021.40	$1,847.53	0.914
2004	$2,161.10	$2,552.18	1.181
2005	$2,304.98	$2,739.99	1.189
2006	$2,257.38	$2,454.98	1.088
2007	$2,308.31	$2,470.81	1.070
2008	$2,279.51	$2,773.04	1.217
2009	$2,235.70	$2,235.70	1.000
2010	$2,250.59		
2011	$2,269.06		

PART A & PART B:

Calendar Year	ESRD Current Estimate	ESRD Published Estimate	Ratio
2000	$2,988.24	$3,879.26	1.298
2001[1]	$3,304.30	$3,417.33	1.034
2001[2]	$3,304.30	$3,518.87	1.065
2002	$3,455.12	$3,450.41	0.999
2003	$3,592.25	$3,444.11	0.959
2004	$3,843.63	$4,237.43	1.102
2005	$3,894.29	$4,499.89	1.156
2006	$3,893.14	$4,172.95	1.072
2007	$3,995.35	$4,345.35	1.088
2008	$4,091.91	$4,628.07	1.131
2009	$4,146.77	$4,146.77	1.000
2010	$4,246.77		
2011	$4,346.16		

[1]Applies to M+C ratebook for January to February, 2001
[2]Applies to M+C ratebook for March to December, 2001

Summary of Key Projections Under Present Law[1]

Part A

Year	Calendar Year CPI Percent Increase	Fiscal Year PPS Update Factor	FY Part A Total Reimbursement (Incurred)
2000	3.5	1.1	-0.8
2001	2.7	3.4	7.9
2002	1.4	2.8	7.7
2003	2.2	3.0	3.9
2004	2.6	3.4	8.5
2005	3.5	3.3	8.9
2006	3.2	3.7	5.8
2007	2.8	3.4	6.5
2008	2.8	3.3	8.3
2009	2.5	2.8	7.9
2010	2.8	1.4	6.4
2011	2.8	2.8	6.0

Part B[2]

Calendar Year	Physician Fee Schedule		Part B Hospital	Total
	Fees	Residual[3]		
2000	5.5	3.6	-0.8	10.4
2001	4.8	4.1	12.5	9.7
2002	–4.8	6.1	-1.4	6.1
2003	1.7	4.5	5.4	6.9
2004	1.5	5.9	9.9	9.7
2005	1.5	3.3	8.3	6.8
2006	0.2	4.7	4.5	5.9
2007	0.0	4.0	2.2	3.3
2008	–4.6	5.2	4.7	3.9
2009	–10.4	6.6	6.5	1.7
2010	–5.5	3.2	7.0	2.9
2011	–5.3	3.2	6.6	2.9

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

Medicare Enrollment Projections Under Present Law (In Millions)

Non-ESRD

Calendar Year	Part A		Part B	
	Aged	Disabled	Aged	Disabled
2000	33.700	5.222	32.421	4.590
2001	33.904	5.416	32.582	4.747
2002	34.080	5.619	32.713	4.915
2003	34.427	5.929	33.027	5.187
2004	34.837	6.249	33.282	5.458
2005	35.244	6.574	33.584	5.747
2006	35.781	6.820	33.960	5.975
2007	36.361	6.965	34.363	6.128
2008	37.032	7.042	34.927	6.197
2009	37.793	7.178	35.557	6.318
2010	38.503	7.398	36.131	6.496
2011	39.408	7.570	36.833	6.646

ESRD Part A

Calendar Year	Part A			
	Aged	Disabled	299I[1]	Total
2000	0.136	0.109	0.088	0.333
2001	0.144	0.115	0.091	0.349
2002	0.151	0.120	0.094	0.366
2003	0.160	0.126	0.096	0.383
2004	0.167	0.132	0.100	0.399
2005	0.174	0.137	0.104	0.415
2006	0.182	0.141	0.107	0.430
2007	0.190	0.143	0.110	0.443
2008	0.199	0.144	0.113	0.455
2009	0.206	0.146	0.116	0.468
2010	0.213	0.149	0.118	0.480
2011	0.219	0.152	0.120	0.491

ESRD Part B

Calendar Year	Part B			
	Aged	Disabled	299I	Total
2000	0.138	0.104	0.082	0.324
2001	0.145	0.110	0.084	0.338
2002	0.153	0.114	0.087	0.354
2003	0.161	0.120	0.088	0.370
2004	0.168	0.125	0.089	0.382
2005	0.175	0.130	0.092	0.396
2006	0.183	0.133	0.095	0.411
2007	0.190	0.135	0.097	0.422
2008	0.198	0.135	0.100	0.433
2009	0.206	0.137	0.102	0.444
2010	0.212	0.140	0.103	0.455
2011	0.218	0.143	0.105	0.466

[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	2,385.85	310.23	104.90	99.05	70.38	593.36	269.74	2,772	146
2001	2,406.91	2,595.76	376.02	129.04	121.53	64.75	571.77	255.43	3,575	188
2002	2,578.76	2,780.67	411.58	145.08	130.36	69.82	523.26	227.72	4,391	231
2003	2,670.88	2,863.47	420.10	149.83	132.99	72.01	522.57	218.64	5,428	286
2004	2,776.44	3,007.09	469.84	173.01	143.45	78.03	569.12	236.84	6,506	342
2005	2,886.98	3,141.22	513.73	193.18	151.58	82.66	675.62	300.03	7,612	401
2006	2,837.70	3,134.52	542.50	206.19	151.98	83.23	823.75	474.01	8,748	460
2007	2,829.10	3,213.58	565.07	221.10	154.92	87.39	984.40	666.45	9,453	498
2008	2,939.56	3,435.57	583.27	235.54	154.64	89.99	1,175.32	805.09	10,113	532
2009	3,029.56	3,601.65	601.50	248.51	155.54	92.45	1,300.70	897.73	10,854	571
2010	3,109.61	3,728.42	619.02	259.56	156.74	94.37	1,405.86	975.24	11,658	614
2011	3,184.88	3,861.11	634.19	271.16	156.90	96.05	1,499.60	1,043.05	12,510	658

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

Part B Projections Under Present Law[1]

Calendar Year	Physician Fee Schedule		Part B Hospital		Durable Medical Equipment	
	Aged	Disabled Non-ESRD	Aged	Disabled Non-ESRD	Aged	Disabled Non-ESRD
2000	1,003.19	951.69	238.98	290.69	118.54	184.47
2001	1,131.47	1,064.17	326.94	400.13	137.14	215.29
2002	1,177.46	1,109.73	333.67	423.49	158.40	261.50
2003	1,263.13	1,190.84	378.19	470.64	182.20	302.52
2004	1,393.46	1,311.26	429.01	545.24	180.98	301.14
2005	1,452.56	1,355.63	472.86	584.41	181.59	304.17
2006	1,457.68	1,335.63	489.78	599.35	185.65	314.41
2007	1,430.16	1,327.52	486.21	613.63	181.03	315.26
2008	1,371.02	1,295.41	496.09	639.55	185.69	333.65
2009	1,279.68	1,222.91	523.40	682.54	179.85	328.19
2010	1,230.21	1,184.36	556.97	731.97	185.64	342.21
2011	1,184.41	1,148.13	591.38	782.77	191.75	357.18

Calendar Year	Carrier Lab		Other Carrier		Intermediary Lab	
	Aged	Disabled Non-ESRD	Aged	Disabled Non-ESRD	Aged	Disabled Non-ESRD
2000	58.89	61.22	201.38	195.17	46.25	59.30
2001	64.86	66.15	239.97	231.14	47.73	64.78
2002	70.96	74.14	286.95	281.69	55.38	74.69
2003	76.42	79.72	337.18	349.92	60.27	80.00
2004	82.37	86.53	362.42	395.20	65.27	88.18
2005	86.79	91.26	371.40	422.84	67.49	91.92
2006	89.80	95.03	376.42	387.94	67.83	92.96
2007	92.25	105.97	381.02	397.92	63.98	90.82
2008	94.33	113.32	413.89	446.22	62.72	90.94
2009	100.76	122.32	452.17	489.48	64.52	94.60
2010	106.57	130.27	492.00	532.51	66.92	98.85
2011	112.57	138.55	535.41	580.30	69.81	103.84

Calendar Year	Other Intermediary		Home Health		Managed Care	
	Aged	Disabled Non-ESRD	Aged	Disabled Non-ESRD	Aged	Disabled Non-ESRD
2000	117.91	108.13	129.45	99.19	531.83	221.42
2001	138.59	114.61	125.20	104.59	498.03	189.91
2002	173.74	143.90	131.98	110.78	494.67	205.08
2003	179.80	138.02	139.32	117.10	481.20	199.56
2004	205.83	165.80	159.56	133.66	537.12	233.86
2005	227.89	178.59	183.06	154.29	624.54	291.73
2006	225.97	187.06	206.98	176.21	836.07	531.56
2007	222.49	187.29	241.42	206.61	1,017.79	683.90
2008	226.83	198.19	257.46	225.22	1,216.35	825.41
2009	225.11	199.81	268.08	238.03	1,333.73	884.49
2010	233.98	210.00	275.19	247.02	1,430.58	956.74
2011	243.47	220.94	276.61	251.43	1,523.40	1,024.61

[1]Average 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	0.001245	0.007126
2007	0.000968	0.006067
2008	0.000968	0.006067
2009	0.000968	0.006067
2010	0.000968	0.006067
2011	0.000968	0.006067

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 .97612 to get the USPCC for the aged non-ESRD. This final factor of .97612 is the relationship between the total and non-ESRD per capita reimbursements in 2009. 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 .96457 to get the USPCC for the aged non-ESRD.

The National Per Capita MA Growth Percentage:

The National Per Capita MA Growth Percentage for 2009 (before adjustment for prior years' over/under estimates) is calculated by adding the USPCCs for Part A and Part B for 2009 and then dividing by the sum of the current estimates of the USPCCs for Part A and Part B for 2008.

Attachment III. Responses to Public Comments

Key Policy Changes from the Advance Notice

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

Attachment III, Section E announces the policy decision on the MA coding intensity adjustment for 2009.

Attachment III, Section F provides information on upcoming audit activities.

Attachment III, Section G announces that the CMS is unable to determine for CY 2009 whether an adjustment other than zero to the FFS rates is appropriate to reflect the cost of services obtained by MA enrollees at VA and DoD facilities.

Attachment III, Section I announces that CMS is still preparing the final rule concerning the reporting of drug costs for Part D sponsors that contract with PBMs, and discusses Part D sponsors' options for pricing.

Attachment III, Section J announces that the proposal in the Advance Notice on calculation of the low-income benchmark premium amount is replaced by the approach announced in the final rule CMS-4133-F, titled "Modification to the Weighting Methodology Used to Calculate the Low-income Benchmark Amount," published on April 3, 2008.

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

Key Policies Adopted as Proposed in the Advance Notice

Recalibration of the CMS-HCC model. In 2009, CMS will implement an updated version of the aged-disabled CMS-HCC risk adjustment model, including community, institutional, and new enrollee segments of the model. See Section B below for comments and responses regarding the recalibrated model. See Attachment IV, Tables 1, 2, and 3 for the final 2009 model coefficients.

Recalibrated frailty factors. CMS will implement recalibrated frailty factors for CY 2009. See Attachment IV, Table 4 for the final factors.

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 Announcement (published April 2, 2007). PACE frailty scores for payment year 2009 will be calculated at a blend of 70% of the frailty factors in use prior to 2008 and 30% of the recalibrated frailty factors implemented in 2009.

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 Announcement (published April 2, 2007): Social Health Maintenance Organizations (S/HMOs), Minnesota Senior Health Options (MSHO)/ Minnesota Disability Health Options (MnDHO), Wisconsin Partnership Program (WPP) and Massachusetts Senior Care Options (SCO) plans. The phase out schedule for 2009 is 50% of the pre-2008 frailty factors.

Normalization Factors. Normalization factors for 2009 are as follows:

- The final 2009 normalization factor for the aged-disabled model is 1.030.
- The final 2009 normalization factor for the ESRD dialysis model is 1.019.
- The final 2009 normalization factor to be applied to the risk scores of enrollees in functioning graft status is 1.058.
- The final 2009 normalization factor for the RxHCC model is 1.085.

Budget Neutrality. For 2009, 25 percent of the BN factor will be applied to the risk rates.

Medicare as Secondary Payer (MSP) Adjustment Factor for Aged & Disabled Enrollees. CMS has recalculated the MSP adjuster for working aged and working disabled beneficiaries. The adjuster will be 0.174 in the 2009 payment year.

ESRD Bidding and Payment. For 2009, CMS will continue the policy of excluding costs for ESRD enrollees in the plan A/B bid.

For payment year 2009, CMS' payments for ESRD dialysis and transplant enrollees will be based on State rates calculated using a blend of 50% of the old State ratebook (in use through 2007) and 50% of the revised State ratebook (implemented in 2008).

For 2009 CMS will continue to use the functioning graft coefficients published in the April 7, 2007 Advance Notice for 2008, when the ESRD dialysis model was last recalibrated. (See above for the 2009 normalization factor to be used with the functioning graft risk scores.)

Regional Plan Stabilization Fund. Section 101 of the Medicare, Medicaid, and SCHIP Extension Act of 2007 – enacted December 18, 2007 – delayed Stabilization Fund payments until January 1, 2013.

Continuation of Clinical Trial Policy. In 2009, 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.

Reporting of Medicaid Status for Part C Payment. In CY 2009, CMS will complete the transition to using the MMA Medicare/Medicaid Dual Eligible monthly submission file (MMA State files) as the main source of Medicaid status for Part C plan payments. The data sources for the assignment of Medicaid status can be found in Attachment IV, Table 5.

Standard Set of ICD-9 Diagnosis Codes for Risk Adjustment. Starting with payment year 2009, RAPS will only accept valid ICD-9-CM codes for two fiscal years -- the fiscal year that begins prior to the payment year and the fiscal year that begins during the payment year -- for the CMS-HCC, ESRD, and RxHCC risk adjustment models. For example, for diagnoses codes to be used

in 2009 final payment, i.e., for diagnoses from service dates between January 1, 2008 and December 31, 2008, RAPS will only accept codes that are valid for Fiscal Year 2008 and Fiscal Year 2009. See Attachment IV, Table 6 for the acceptable codes.

Medicare Part D Benefit Parameters: Annual Adjustments for Defined Standard Benefit in 2009. 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. See Attachment IV, Table 7 for the 2009 updated Part D benefit parameters for the defined standard benefit, low-income subsidy, and retiree drug subsidy.

Calculation of the Part D National Average Monthly Bid Amount. CMS will complete the transition to the weighted average method based on actual plan enrollments in 2009. Thus for contract year 2009, 100% of the national average monthly bid amount will be based on the enrollment-weighted average.

Coordination of Benefits (COB) User Fees. Upon review of the anticipated costs of COB activities in 2009, the Part D COB user fee will increase to $2.52 per enrollee per year for contract year 2009. This COB user fee will be collected at a rate of $0.28 per enrollee per month from January to September (for an annual rate of $0.21 per enrollee per month) for a total user fee of $2.52 per enrollee per year. Part D sponsors should account for this COB user fee when developing their 2009 bids.

Budget Neutrality Offsets for Reinsurance Payment Demonstration Plans in 2009. The budget neutrality offsets applied to the capitated reinsurance payments for flexible capitated, fixed capitated, and Medicare Advantage rebate option plans will remain at $10.00 per member per year for contract year 2009.

Payment Reconciliation. The 2009 risk percentages and payment adjustments for Part D risk sharing are unchanged from contract year 2008. The risk percentages for the first and second thresholds remain at 5% and 10% of the target amount respectively for 2009. The payment adjustments for the first and second corridors are 50% and 80% respectively.

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

Section A. Estimate of the National Per Capita MA Growth Percentage for Calendar Year 2009

As mentioned in Attachment I, the final estimate of the 2009 MA growth trend for combined aged and disabled beneficiaries is 4.24 percent, which is a little lower than the preliminary estimate of 4.8 percent announced February 22, 2008 in the Advance Notice. The President's Budget baseline was used for the preliminary estimate, and the 2008 Trustees Report baseline was used for the final estimate. The primary reason for the lower final estimate is that cash expenditure data for the remainder of 2007 was available which indicated that the actual expenditures for 2007 were lower than previously estimated.

The manner in which the Tax Relief and Health Care Act (TRHCA) of 2006 and the Medicare, Medicaid, and SCHIP Extension Act (MMSEA) of 2007 structured the physician fee schedule increase affects both the adjustment to the 2008 growth rate and the 2009 trend as compared to the 2009 trend reported in the 2007 Trustees Report. About 1 percentage point of the 1.9 percent increase in the 2008 trend is due to legislative changes in the physician fee schedule update, because the previously expected -10 percent adjustment for 2008 was eliminated for half of the year and replaced with a 0.5 percent update. For the second half of the 2008, the update will revert to the current law update of -10 percent, as required by the MMSEA of 2007. Hence, the average for the year is approximately a -5 percent update. The -5 percent update compared to the previously expected -10 percent update increases the overall USPCC growth rate for 2008 by about 1 percent.

However, this revision to the prior 2008 estimate of about a 1 percent increase is offset by a reduction in the 2009 trend change. That is because, under the MMSEA, the 2008 increase has no effect on the calculation of the 2009 physician fee schedule update. As a result, the current law baseline for 2009 reflects a -10 percent update for physician fees. The net impact on the overall 2009 USPCC of this -10 percent update compared to the -5 percent for 2009 as reported last year is about a 1 percent decrease in the trend.

Comment: One commenter believes that the proposed 2009 trend change in the Advance Notice of 3.4% is too low and does not reflect the underlying increases in Medicare health care costs. This commenter feels that CMS should increase the 2009 trend change in the final notice to at least 4.5 percent to be aligned with other CMS estimates of Medicare growth. In addition, this commenter was concerned with the downward adjustments in the growth percentage for 2005 and 2007 and recommended that CMS increase these adjustments to previous years' trend changes and provide a detailed explanation for these proposed changes. Finally, the same commenter recommended that CMS recalculate the estimate of 100% FFS costs for previous years to account for increased Medicare physician payments and trend forward to the 2009 rates.

Response. By law, CMS must release the national MA growth percentage for the upcoming year by the first Monday in April. In years when legislative changes to the physician fee schedule updates are passed after April, such changes are not incorporated into the MA growth trend until the following year, when they are reflected as adjustments to the prior years' estimates. The Tax Relief & Health Care Act (THRCA) of 2006 and the Medicare, Medicaid, and SCHIP Extension Act (MMSEA) of 2007 explicitly limited the increased physician fee schedule updates—for 2007 and for the first half of 2008, respectively, to specific time periods. Moreover, the TRHCA required that the physician fee schedule update for 2008 must be calculated as if the 2007 increase did not occur. Similarly, the MMSEA requires that the physician fee schedule update for the last six months of 2008 and 2009 must be calculated as if the increase for the first six months of 2008 did not occur. As a result, in 2007 and 2008, OACT had to estimate underlying trends for CYs 2008 and 2009, respectively, based on current law updates of approximately -10%.

Regarding the commenter's question about prior years' estimates, the additional adjustments to the 2004 to 2006 growth rates are fairly insignificant and for the three years combined are slightly positive. Since the Medicare growth rates are tabulated on an incurred basis, it can take several years before all bills for a given year are tabulated through the claims history file. This is

why we can still see small changes for years back to 2004. The latest estimates for 2007 were based on incurred data reported through June of 2007. Hence, the claims history for 2007 is relatively incomplete. CMS has cash data through December 2007 from the U.S. Treasury, which indicates that outlays for 2007 were lower than expected. Therefore, the expected increase for 2007 was lowered. As more incurred data is received for 2007, adjustments will be made to account for the actual 2007 trend rates as allowed by law in future payment updates.

Regarding the commenter's recommendation that CMS recalculate the estimate of 100% FFS costs for previous years to account for increased Medicare physician payments and trend forward to the 2009 rates, this is not necessary. The law already allows for adjustments to the growth percentage for prior years' over/underestimates. Therefore, increased payments due to the prior legislative physician updates are already accounted for. In addition, the historical data which is used for calculating the geographic indices for the 100% FFS costs also reflect all prior legislative changes.

Section B. Recalibration of the CMS-HCC Model

Comment. One commenter stated that recalibrating on a biannual basis adds significant uncertainty for MA organizations because of the complexity of estimating the impact of recalibration as they engage in the bid development process and consider strategies for continuing to provide comprehensive and stable benefit packages to enrollees. The commenter recommended that CMS recalibrate the model once every three years, instead of biannually, in order to provide MA organizations with more predictability, while also ensuring the risk adjustment model continues to be based upon regularly updated data. Another commenter was concerned about significant year-to-year variations in MA payments accompanying the recalibration of the CMS-HCC risk adjustment model, and requested that CMS explore opportunities to reduce such variations. In particular, this commenter was concerned that plans in certain geographic areas not be disadvantaged over other plans in other geographic areas.

Response. CMS' policy goal is to recalibrate every two years to strike a balance between updating the model to reflect recent shifts in average relative expenditures among disease groups and reducing the burden of annual model changes. Recalibrating every three instead of every two years could generate more significant shifts in the relative cost factors for each HCC grouping, which could increase the relative level of changes in payments and the degree of uncertainty for the industry. Moreover, CMS seeks to align recalibration of the CMS-HCC model with rebasing of the FFS rates.

In terms of the commenter's request that CMS consider ways to reduce differential geographic impacts, CMS recalibrates the CMS-HCC model using actual FFS diagnoses and claims expenditures. We are not clear what options we could explore to reduce actual geographic variation.

Comment. Two commenters requested that CMS post to the Health Plan Management System (HPMS) as soon as possible the recalibrated risk scores for plans. The commenters noted that this information is critical in order to develop accurate bids. One commenter also noted that it is

difficult to comment on a new model without knowledge of how that model could impact their plan.

Response. Plan-specific recalibrated risk scores will be available through HPMS the week of April 7, 2008, in conjunction with the final bid instructions. In addition, the 2009 CMS-HCC model software reflecting the model recalibrated risk factors was posted March 7, 2008 on the CMS website at http://www.cms.hhs.gov/MedicareAdvtgSpecRateStats/06_Risk_adjustment.asp#TopOfPage.

Comment. One commenter requested that CMS publish frequency tables that show the estimated number of beneficiaries who fall into each HCC category under the existing and recalibrated models (e.g., the percent of members with HCC1 in 2004 and also in 2005) in the 2009 Rate Announcement, and in future Advance Notices. The commenter indicated that this information will assist plans in evaluating the impact of the recalibration as they develop their bids.

Response. This information is available through analysis of the 5 percent Standard Analytic File (SAF). CMS provides the CMS-HCC model software, as mentioned above, to facilitate the analysis described by the commenter.

Comment. One commenter expressed concern that the recalibrated risk factors could result in plan risk score reductions that would drop risk adjusted payments below the level of budget neutrality. The commenter requested that CMS publish the math and supporting documentation for the recalibration of the CMS-HCC coefficients.

Response. In terms of the relationship of recalibrated model factors to the budget neutrality factor, CMS determined the budget neutrality factor for 2009 using the recalibrated risk scores for each plan. Specifically, the BN factor 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. The size of the total BN factor is determined by the difference in aggregate payments made to MA organizations under the recalibrated risk model and aggregate payments made under the demographic model. Therefore, the effect of the recalibrated model is taken into account when the BN factor is calculated. As we noted in the Advance Notice, for 2009, 25 percent of the BN factor is applied to the risk rates that have been released with this Announcement.

Comment. One commenter expressed concern that their preliminary estimates of the impact of the recalibrated CMS-HCC model leads to a reduction in risk scores.

Response. . At the aggregate level, model recalibration has a neutral effect on the MA risk scores. When we recalibrate, the relative payment weights (risk factors) in the model can change, potentially affecting plan-specific average risk scores. The plan-specific impact will depend on the disease profile of the beneficiaries enrolled in the plan.

Section C. Normalization Factors

Comment. One commenter expressed appreciation that CMS released preliminary estimates of the normalization factors. The commenter also expressed concern that the CMS-HCC factor

represents a 3 percent reduction to risk scores, which will offset any increase in the MA capitation rates. The commenter recommended that CMS reduce the normalization factor and continue to do so as the BN factor is phased-out because continuing high negative adjustments will negatively impact MA payments as budget neutral risk-adjustment is phased out.

Response. CMS is required by the Deficit Reduction Act of 2005 to phase-out the implementation of budget neutral risk-adjusted payments (i.e., budget neutral to payments based on 100 percent of the demographic rates). Application of the normalization factors addresses an unrelated issue, which is that CMS must correct for population and coding changes between the data years used in calculating the model relative factors (the "denominator year") and the payment year. CMS cannot phase-out application of normalization factors because there will always be a lag between denominator and payment years.

Comment. One commenter requested additional information regarding how the 2009 normalization factor for the RxHCC model was determined because the factor of 1.085 appears to be a significant recalibration of Rx risk scores. The commenter requested additional explanation of how the annual trend is calculated and how it is applied for the two years between the calculation of actual average Part D risk score and the payment year (2007-2009). In addition, the commenter asked what prescription drug data was used before Part D began in 2006.

Response. The Part D normalization factor was 1.065 for 2008, and will be 1.085 for 2009. To calculate the 2009 Part D normalization factor, which will adjust for coding trends from the calibration year (2004) to the payment year (2009), we first obtained the actual trend in Part D risk scores by using the actual 2007 average Part D risk score for all potential Part D enrollees. We then projected the trend from 2007 to 2009 using an annual trend calculated on five years of risk score data (2003-2007). We calculated this trend the same way we calculated the trends for the CMS-HCC and the ESRD dialysis factors: we first calculate average predicted costs using the most recent model (in the case of the Rx-HCC model, we have only one model) for the most recent five years for which we have complete diagnosis data. We then use these data points to estimate the annual average trend in predicted costs. We applied this annual trend for the years between 2007 to 2009 and added it to the actual trend identified by the 2007 average Part D risk score. This downward adjustment, which helps ensure that the average risk score across all Part D plans equals 1.0, will not affect total plan revenue.

For information on what prescription drug data was used for initial calibration of the Part D Rx-HCC model, see the 2006 Advance Notice, Attachment III (pages 43-48), released on February 18, 2005 on the CMS website at http://www.cms.hhs.gov/MedicareAdvtgSpecRateStats/AD/list.asp#TopOfPage.

Section D. Budget Neutrality

The final estimate of the National Per Capita MA Growth Percentage is not the only factor that determines the final capitation rates for a year. 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 estimated as the difference

between aggregate payments to plans using 100 percent demographic payments and aggregate payments to plans using 100 percent risk adjustment payments, expressed as a percent of risk adjusted payments. For purposes of the calculation, CMS assumes that risk payments to plans will be at the local benchmarks, adjusted for each plan's risk score. CMS calculates a single BN factor for all MA plan enrollees.

The BN factor estimate for 2009 is 1.009. This factor was calculated based on a full BN factor of 1.038, multiplied by the BN phase-out percentage of 25 percent. As 2009 is the third year of the phase-out required by the DRA of 2005, 25 percent of the full BN factor is applied to the rates, as the same percentage for all counties.

Comment. One commenter requested that CMS release the BN factor before the Rate Announcement is released because of the shortened time frame in 2008 between release of the Announcement and the bid due date.

Response: Since CMS cannot calculate the BN factor until the final capitation rates are determined, and the final capitation rates are not determined until the National Per Capita MA Growth Percentage is determined (using the 2008 Trustees Report baseline), it is not possible for CMS to release the BN factor prior to the April 7 release of the Rate Announcement and final capitation rates.

Section E. Adjustment for MA Coding Intensity

In the 2009 Advance Notice, CMS summarized findings from our analysis of risk scores in FFS and Medicare Advantage over the 2004-2006 time period and proposed to apply a coding difference adjustment to contracts whose disease scores for stayers exceeded FFS by twice the industry average. We proposed to apply an adjustment calculated based on those contracts that fell above our threshold.

In response to the Advance Notice, CMS received a significant number of comments on the proposed adjustment for MA coding differences, most of which disagreed with our view that we had identified differences in coding patterns between MA and FFS Medicare. Based on our analysis of the comments received, and our further consideration of the question of whether differences in risk scores can be attributed to differences in coding patterns, we have again decided not to make a coding intensity adjustment for 2009.

We hope to be able to reach a more definitive conclusion as to whether differences in risk scores are attributable to differences in coding patterns prior to the Rate Announcement for 2010. In the Advance Notice, we identified differences between the risk scores of MA and FFS Medicare enrollees. However, we did not have available comprehensive information from medical records to support our hypothesis that risk score differences were driven by coding pattern differences, rather than by the health status of MA enrollees. For 2010, we intend to use the results of the first year of plan-level annual MA plan audits (see section F below) to further inform our study of coding pattern differences. .Moreover, CMS will collect additional utilization data from MA organizations to increase the accuracy of our risk-adjusted payments.

Below, we summarize and respond to the comments received on the proposed coding intensity adjustment.

(1) Legal Justification for the MA Coding Intensity Adjustment

Comment. Twenty-nine of the 30 commenters on the Advance Notice expressed views on our coding intensity proposal, and all but one of these 29 commenters opposed the adjustment as proposed. The commenter who supported the adjustment was encouraged by CMS' efforts to implement the Deficit Reduction Act (DRA) provision, but argued that CMS had too narrowly defined the subset of plans targeted to have their risk scores adjusted, and felt that CMS' effort to correct upcoding was minimal and unacceptable. Twenty eight commenters opposed the adjustment. Many contended that CMS has not demonstrated that conclusive evidence of coding differences exists, and contended that CMS had not met the requirement in the Deficit Reduction Act (DRA) that the Secretary must identify differences in coding patterns in order to adjust capitation payments to "reflect […] differences in coding patterns between Medicare Advantage plans and providers under part A and B…" Some commenters suggested that CMS defer implementation of the DRA provision pending completion of further research and analysis to determine the extent of coding inaccuracies by MA organizations.

Response. As noted above, CMS has determined that for CY 2009, we will not make an adjustment to risk scores when calculating 2009 plan payments. We believe that the results of the Audits discussed below in Section F will result in an ability to determine more conclusively whether the differences in risk scores we have identified are attributable to differences in coding patterns.

Comment. Authority under the DRA. Many commenters cited the Deficit Reduction Act (DRA) requirement directing CMS to adjust capitation payments 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" and contended that CMS has not demonstrated that evidence of such differences exists. Further, numerous commenters also cited the Conference Report for the DRA, which states that "The conferees intend that any adjustments made for the differences in coding patterns be made for differences resulting from inaccurate coding." These commenters interpret the conferees' use of the term "inaccurate" to refer to "improper" or fraudulent coding, and noted that, in the 2009 Advance Notice, CMS stated that "We do not assume that the coding pattern differences that we found in our study are the result of improper coding." The commenters thus argued that CMS does not have the authority to make adjustments based on the coding pattern differences that CMS found. Some commenters suggested that CMS defer implementation of the DRA provision pending completion of further research and analysis to determine the extent of coding inaccuracies by MA organizations.

Response. CMS believes that the statutory language in the DRA provision at issue provides for a payment adjustment if CMS establishes that there are "differences in coding patterns between Medicare Advantage plans and providers under part A and B." The Conference Report language necessarily must be read in light of the statutory language that Congress actually enacted.

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

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

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

Comment. Several commenters contended that the DRA provision requiring a coding intensity adjustment did not provide for an adjustment that would be applied to a subset of plans, as opposed to the MA program generally.

Response. The DRA requires that, in "applying the adjustment under [section 1853(a)(1)(C)(i)] for health status to payment amounts, the Secretary shall ensure that such adjustment reflects. . .differences in coding patterns between the Medicare Advantage plans and providers under Part A and B to the extent that the Secretary has identified such differences." Section 1853(a)(1)(C)(ii)(I). The adjustments to capitation rates made under section 1853(a)(1)(C)(i) generally are specific to a particular MA organization. In the case of adjustments based on an enrollee's risk score, they are specific to the plan's individual enrollees. In the case of adjustments made to reflect working aged enrollees, they are made at the plan level based on that plan's enrollees.

We believe, therefore, that if we had made a final determination that an adjustment for 2009 was justified, we would have had the authority to make adjustments where we found the greatest differences in coding patterns (and where such adjustments arguably would be more necessary in order for risk scores to have the same meaning for MA enrollees and original Medicare enrollees), while not doing so where there are no such differences, or where the difference is of a smaller magnitude.

(2) Purpose of coding differences adjustment and informing of public of final methodology

Comment. One commenter contended that the Advance Notice did not make clear precisely the purpose of the proposed coding intensity adjustment, other than citing the Deficit Reduction Act (DRA). Other commenters felt that CMS had not adequately demonstrated the need for such an adjustment for coding pattern differences, and had not identified with any certainty the reasons

for the difference. Commenters suggested that there were other explanations of coding pattern differences, such as regional coding pattern differences, other than those identified by CMS.

Response. The DRA requires that CMS adjust payments 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." While we have reconsidered our view that the differences that we found were conclusively the result of coding pattern differences, if we had reached such a conclusion, an adjustment would have been appropriate without regard to the findings cited by commenters.

(3) Impact of plans, markets, beneficiaries

Comment. While some commenters felt that CMS too narrowly limited the number of contracts to which the adjustment would be applied, and a few others agreed with the CMS proposal to apply the adjustment to plans whose risk score change relative to FFS Medicare is significantly above the average change relative to FFS Medicare, many commenters expressed concerns that applying an adjustment to a subset of contracts was inequitable and had anti-competitive implications.

Several commenters felt that the adjustment penalized MA organizations that have been in the program longer and are now operating more efficiently. A number of commenters posited that the coding adjustment could discourage providers from contracting with plans that received the coding intensity adjustment, since MA organizations, especially those that pay providers a percent of revenue, may have to lower provider payments, which might lead to difficulty in maintaining provider networks and accessibility of care, instability in beneficiary access to care, and consumer dissatisfaction if their physicians leave the plan. Commenters also expressed concern that a coding intensity adjustment would lead to increased premiums and cost sharing and decreased benefits, and possibly cause disruption for beneficiaries who may then feel that they have to disenroll from their plan, and who may then have to switch providers. One commenter suggested that plans will lack incentive to enroll sicker, higher-risk patients. Several commenters expressed concern about the ability of plans to continue to provide appropriate care.

Response. We appreciate commenters' concerns regarding their perceptions of inequity in applying a coding differences adjustment to a subset of contracts and the market implications of such a targeted approach. Because we have decided not to make an adjustment for 2009, the above issues are moot for the 2009 bidding process.

(4) Methodological Questions and Concerns

Comment. Commenters disagreed with CMS's proposal to use the average stayer percentage to adjust the adjustment factor, in order to apply it to all enrollees, noting changes in enrollment over the time period of the study, and variations in stayer percentages among contracts as a result of different enrollee populations. Other commenters felt that an adjustment would disadvantage MA organizations with sicker enrollees. Several commenters suggested that an adjustment for coding pattern differences would discourage initiatives to improve coding, or to maintain thorough coding, since increased coding might risk a revenue reduction in future years. Several

commenters disagreed that CMS had taken into full account the degree of "catch up" and felt that a number of MA organizations would face the possibility of being penalized for these efforts.

Response. We appreciate commenters' concerns about the methodology of our approach to calculating and applying an MA coding differences adjustment. Because we are not making an adjustment for 2009, these comments are moot for this year.

Comment. One commenter suggested that CMS identify strategies for improving coding accuracy in FFS to reduce the variance in coding patterns directly related to differences in financial incentives between MA and FFS – strategies such as risk-adjusting FFS payments.

Response. CMS does make adjustments to FFS payments for diagnosis coding that is not in synchronization with a provider's case mix. We have applied an adjustment to long term hospitals that is projected to total $430 million over five years (FY 2009-FY 2013) and to home health providers that is projected to total $6.53 billion from 2008-2012.

Section F. CMS Audits

In CY 2007, CMS' payments to MA plans were 100 percent risk-adjusted for the first time because the transition from demographic-only to risk-adjusted payments was completed. Given this milestone, CMS has determined that our Risk Adjustment Data Validation, starting with CY 2007 payments, will be conducted using a sampling frame that generates statistically valid plan-level payment error estimates for those plans selected for review.

CMS will audit a subset of MA plans each year. The audit will include randomly-selected plans and targeted plans. Targeted plans will be selected based on how their risk score growth compared to FFS.

Findings from our validation studies from CY 2007 onward may inform CMS why plan average risk scores did or did not grow rapidly. This analysis will allow us to further refine our MA coding intensity adjustment. In addition, because we will have statistically-valid plan-level error estimates, we will make plan-level payment adjustments rather than adjustments to payments for specific beneficiaries whose risk scores were not supported by the medical record reviews, as we have done previously.

Section G. Adjustment to FFS Capitation Rates for VA-DOD Costs

In the Advance Notice, CMS proposed to adjust to the extent appropriate the 2009 FFS 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." Specifically, the Office of the Actuary (OACT) proposed to compare the risk-adjusted Medicare reimbursements of dual-eligible individuals — those entitled to benefits under this title and entitled to benefits from the Department of Defense (e.g., DoD TRICARE for Life and DoD US Family Health Plan) or the Department of Veterans Affairs (VA) — with individuals entitled only under this title. In cases where groupings of dual-eligible individuals

(who would possibly have services provided in VA or DoD facilities not reimbursed by Medicare) have risk-adjusted Medicare reimbursements significantly different from other Medicare-eligible individuals, we propose to adjust the MA FFS rates by excluding these individuals from the calculation.

For 2009, CMS will not make the proposed adjustment to the FFS rates. While analysis is underway on VA data, CMS has not yet received the necessary data from DoD. For this reason, CMS is unable at this time to determine the extent to which an adjustment other than zero is appropriate. CMS will continue to work on acquiring the data to support the necessary analysis.

Comment. One commenter commended CMS for moving forward with this analysis and requested an opportunity to obtain a detailed understanding of the methodology that is developed and its anticipated impact as CMS proceeds with this effort.

Response. Over the coming year, CMS is open to discussions with interested parties about the proposed methodology.

Comment. One commenter expressed appreciation that CMS is proceeding to incorporate this adjustment into the FFS rates, but expressed concern that some county capitation rates would be reduced as a result. The commenter recommended that CMS phase-in any VA-DoD-related adjustments that would reduce MA county rates to limit the negative impact on beneficiaries.

Response. As noted above, CMS is unable to determine whether an adjustment other than zero is appropriate for CY 2009. We will take the commenter's concern into account as we continue our analysis.

Section H. Standard Set of ICD-9 Diagnosis Codes for Risk Adjustment

Comment. One commenter supported CMS's adoption of a standardized list of diagnosis codes for risk adjustment and asked if CMS would provide a crosswalk to plans between the old and new codes. The commenter also asked if CMS had done any analysis on the impact of establishing this change (e.g., estimates of increases in rejection rates and/or associated financial impact).

Response. ICD-9 codes are updated on an annual basis. You can find additional information on this process at: www.cdc.gov/nchs/icd9.htm. CMS has been monitoring rejection rates for invalid ICD-9 codes since January 2008 when edits against the standardized code set were implemented in the Risk Adjustment Processing System. CMS has seen no evidence of an increase in error rates for invalid ICD-9 codes, strongly suggesting that MA organizations were themselves operating under this standard before CMS implemented the edits. A complete listing of the risk adjustment diagnosis codes acceptable for risk adjustment prior to January 2008 and after implementation of the change in editing rules is available on the CMS website at http://www.cms.hhs.gov/MedicareAdvtgSpecRateStats/06_Risk_adjustment.asp#TopOfPage .

Section I. Part D – Reporting Drug Costs When Contracting with a Pharmacy Benefit Manager (PBM)

In the Advance Notice, we stated that we intended to issue a final rule this Spring concerning the reporting of drug costs for Part D sponsors that contract with PBMs. We are still preparing this final rule and therefore are unable to issue the final rule this Spring as expected. As a result, Part D sponsors will not have sufficient time after the release of the final rule to prepare their 2009 bids in accordance with the policies that will be established in this rule. Therefore, for plan year 2009, as in 2006, 2007, and 2008, Part D sponsors that use a PBM may apply either the pass through or lock-in pricing approach when calculating cost-sharing and reporting drug costs. Part D sponsors must choose only one approach and cannot switch between them for purposes of calculating cost-sharing and reporting drug costs. Thus, the chosen pricing approach must be used consistently as a basis for: (i) calculating beneficiary cost-sharing; (ii) accumulating gross covered drug costs; (iii) calculating TrOOP; (iv) reporting drug costs on the Prescription Drug Event (PDE) records; and (v) developing bids submitted to CMS.

To ensure transparency in bid development, all plans will be required to submit an actuarial attestation, through HPMS and in hardcopy, which identifies the pricing approach (lock-in or pass through) that was used in the development of each 2009 bid. Additional information regarding this attestation will be issued in future guidance.

Section J. Part D - Calculation of the Low-Income Benchmark Premium Amount.

In Attachment III, Section B2 of the Advance Notice, CMS proposed to extend to 2009 the regional benchmark weighting component of the "Medicare Demonstration to Transition Enrollment of Low Income Subsidy Beneficiaries." We also noted in this same section that the de minimis component of the demonstration would be replaced by the final version of the proposed rule titled "Option for Prescription Drug Plans to Lower Their Premiums for Low-Income Subsidy Beneficiaries" which was published on January 8, 2008. The objective of both extending the demonstration an additional year and codifying a variation of the de minimis policy in regulation was to reduce the number of LIS beneficiaries who are reassigned to new Part D sponsors because their current plan's premium exceeds the regional LIS benchmark.

A final version of the rule was published on April 3, 2008. The final rule CMS-4133-F is titled "Modification to the Weighting Methodology Used to Calculate the Low-income Benchmark Amount." The final rule changes how the regional benchmarks are calculated and eliminates the need to extend the LIS transition demonstration. Therefore, CMS will not extend the LIS transition demonstration to 2009.

Section K. Part D - Coordination of Benefits (COB) User Fee

Comment: One commenter asked CMS to provide more information on why the COB user fee increased over 85%.

Response: The increase in the COB user fee is due to several new CMS initiatives to improve the coordination of benefits. For example, CMS is replacing the current manual TrOOP balance

transfer process with a streamlined automated transfer process. The increase in the COB user fee reflects, in part, the costs associated with developing and implementing this new automated process. CMS is also working with States to permit more frequent reporting of information regarding low-income status (full dual and LIS files for Medicare Part D). This initiative will enhance the accuracy of LIS data at point-of-sale, thus reducing Part D sponsors' reliance on Best Available Evidence. Recent legislation has mandated that all third party insurers that are secondary to Medicare provide CMS with information regarding other health insurance coverage. The COB user fee also has been increased to reflect the costs associated with receiving and subsequently providing this additional information to Part D sponsors and the TrOOP Facilitator.

Attachment IV 2009 Risk Adjustment Factors, Part D Benefit Parameters, and Other Information

The tables in this enclosure are identical to those published in the February 22, 2008 Advance Notice.

Table IV-1. 2009 Community and Institutional Factors for the CMS-HCC Model

Variable	Disease Group	Community Factors	Institutional Factors
Female			
0-34 Years		0.187	1.026
35-44 Years		0.206	0.884
45-54 Years		0.275	0.888
55-59 Years		0.333	0.943
60-64 Years		0.411	0.943
65-69 Years		0.299	0.971
70-74 Years		0.368	0.931
75-79 Years		0.457	0.835
80-84 Years		0.544	0.775
85-89 Years		0.637	0.704
90-94 Years		0.761	0.614
95 Years or Over		0.771	0.457
Male			
0-34 Years		0.120	1.030
35-44 Years		0.164	0.871
45-54 Years		0.217	0.871
55-59 Years		0.249	0.978
60-64 Years		0.389	1.015
65-69 Years		0.328	1.221
70-74 Years		0.413	1.154
75-79 Years		0.517	1.143
80-84 Years		0.597	1.087
85-89 Years		0.692	1.001
90-94 Years		0.834	0.932
95 Years or Over		0.980	0.743
Medicaid and Originally Disabled Interactions with Age and Sex			
Medicaid_Female_Aged		0.179	0.091
Medicaid_Female_Disabled		0.131	0.091
Medicaid_Male_Aged		0.166	0.091
Medicaid_Male_Disabled		0.077	0.091
Originally Disabled_Female		0.204	0.023
Originally Disabled_Male		0.168	0.023
Disease Coefficients	**Description Label**		
HCC1	HIV/AIDS	0.945	0.967
HCC2	Septicemia/Shock	0.759	0.764
HCC5	Opportunistic Infections	0.300	0.288
HCC7	Metastatic Cancer and Acute Leukemia	2.276	0.824

Variable	Disease Group	Community Factors	Institutional Factors
HCC8	Lung, Upper Digestive Tract, and Other Severe Cancers	1.053	0.470
HCC9	Lymphatic, Head and Neck, Brain, and Other Major Cancers	0.794	0.368
HCC10	Breast, Prostate, Colorectal and Other Cancers and Tumors	0.208	0.182
HCC15	Diabetes with Renal or Peripheral Circulatory Manifestation[1]	0.508	0.459
HCC16	Diabetes with Neurologic or Other Specified Manifestation[1]	0.408	0.459
HCC17	Diabetes with Acute Complications[1]	0.339	0.459
HCC18	Diabetes with Ophthalmologic or Unspecified Manifestation[1]	0.259	0.459
HCC19	Diabetes without Complication[1]	0.162	0.248
HCC21	Protein-Calorie Malnutrition	0.856	0.374
HCC25	End-Stage Liver Disease	0.978	0.654
HCC26	Cirrhosis of Liver	0.406	0.384
HCC27	Chronic Hepatitis	0.406	0.384
HCC31	Intestinal Obstruction/Perforation	0.311	0.345
HCC32	Pancreatic Disease	0.403	0.309
HCC33	Inflammatory Bowel Disease	0.241	0.205
HCC37	Bone/Joint/Muscle Infections/Necrosis	0.535	0.497
HCC38	Rheumatoid Arthritis and Inflammatory Connective Tissue Disease	0.346	0.215
HCC44	Severe Hematological Disorders	1.015	0.493
HCC45	Disorders of Immunity	0.912	0.427
HCC51	Drug/Alcohol Psychosis[3]	0.274	0.000
HCC52	Drug/Alcohol Dependence[3]	0.274	0.000
HCC54	Schizophrenia	0.524	0.351
HCC55	Major Depressive, Bipolar, and Paranoid Disorders	0.353	0.293
HCC67	Quadriplegia, Other Extensive Paralysis	1.011	0.434
HCC68	Paraplegia	0.993	0.434
HCC69	Spinal Cord Disorders/Injuries	0.558	0.225
HCC70	Muscular Dystrophy[3]	0.395	0.000
HCC71	Polyneuropathy	0.327	0.225
HCC72	Multiple Sclerosis	0.599	0.145
HCC73	Parkinson's and Huntington's Diseases	0.592	0.092
HCC74	Seizure Disorders and Convulsions	0.267	0.177
HCC75	Coma, Brain Compression/Anoxic Damage[3]	0.415	0.000
HCC77	Respirator Dependence/Tracheostomy Status	1.867	1.559
HCC78	Respiratory Arrest	1.082	1.235
HCC79	Cardio-Respiratory Failure and Shock	0.578	0.445
HCC80	Congestive Heart Failure	0.410	0.228
HCC81	Acute Myocardial Infarction	0.359	0.424
HCC82	Unstable Angina and Other Acute Ischemic Heart Disease	0.284	0.424
HCC83	Angina Pectoris/Old Myocardial Infarction	0.244	0.290
HCC92	Specified Heart Arrhythmias	0.293	0.207
HCC95	Cerebral Hemorrhage	0.324	0.179
HCC96	Ischemic or Unspecified Stroke	0.265	0.179
HCC100	Hemiplegia/Hemiparesis	0.437	0.039
HCC101	Cerebral Palsy and Other Paralytic Syndromes[3]	0.180	0.000

Variable	Disease Group	Community Factors	Institutional Factors
HCC104	Vascular Disease with Complications	0.610	0.482
HCC105	Vascular Disease	0.316	0.165
HCC107	Cystic Fibrosis	0.399	0.631
HCC108	Chronic Obstructive Pulmonary Disease	0.399	0.359
HCC111	Aspiration and Specified Bacterial Pneumonias	0.703	0.573
HCC112	Pneumococcal Pneumonia, Emphysema, Lung Abscess	0.249	0.181
HCC119	Proliferative Diabetic Retinopathy and Vitreous Hemorrhage	0.252	0.497
HCC130	Dialysis Status	1.349	1.718
HCC131	Renal Failure	0.368	0.388
HCC132	Nephritis	0.125	0.253
HCC148	Decubitus Ulcer of Skin	1.153	0.485
HCC149	Chronic Ulcer of Skin, Except Decubitus	0.449	0.241
HCC150	Extensive Third-Degree Burns[3]	1.416	0.000
HCC154	Severe Head Injury[3]	0.415	0.000
HCC155	Major Head Injury[3]	0.106	0.000
HCC157	Vertebral Fractures without Spinal Cord Injury	0.443	0.161
HCC158	Hip Fracture/Dislocation[3]	0.429	0.000
HCC161	Traumatic Amputation	0.678	0.260
HCC164	Major Complications of Medical Care and Trauma	0.296	0.309
HCC174	Major Organ Transplant Status	0.705	0.920
HCC176	Artificial Openings for Feeding or Elimination	0.662	0.841
HCC177	Amputation Status, Lower Limb / Amputation Complications	0.678	0.260
Disabled/Disease Interactions			
D_HCC5	Disabled_Opportunistic Infections	0.623	1.016
D_HCC44	Disabled_Severe Hematological Disorders	1.036	0.362
D_HCC51	Disabled_Drug/Alcohol Psychosis	0.729	0.299
D_HCC52	Disabled_Drug/Alcohol Dependence	0.310	0.299
D_HCC107	Disabled_Cystic Fibrosis[3]	1.097	-
Disease Interactions			
INT1	DM_CHF[2]	0.154	0.125
INT2	DM_CVD	0.102	0.028
INT3	CHF_COPD	0.219	0.194
INT4	COPD_CVD_CAD	0.173	0.071
INT5	RF_CHF[2,3]	0.231	-
INT6	RF_CHF_DM[2]	0.477	0.358

NOTES:

[1] Includes Type I or Type II Diabetes Mellitus.

[2] Beneficiaries 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. A beneficiary with all three conditions is not "credited" with the two-way interactions. All other interaction terms are additive.

[3] HCC or disease interaction excluded from institutional model because estimated coefficient less than 0 or t-statistic less than 1.0.

The 2007 denominator of $7,463.14 used to calculate both the community and institutional factors is the national predicted average annual cost under the model.

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).

SOURCE: RTI International analysis of 2004/2005 Medicare 5% sample.
SOURCE: RTI International analysis of 2004/2005 Medicare 100% institutional sample.

Attachment IV-2. Disease Hierarchies for the CMS-HCC Model

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.

Attachment IV-3. 2009 CMS-HCC Model for New Enrollees

	Non-Medicaid & Non-Originally Disabled	Medicaid & Non-Originally Disabled	Non-Medicaid & Originally Disabled	Medicaid & Originally Disabled
Female				
0-34 Years	0.496	0.807	0.000	0.000
35-44 Years	0.652	0.963	0.000	0.000
45-54 Years	0.841	1.152	0.000	0.000
55-59 Years	0.969	1.280	0.000	0.000
60-64 Years	1.094	1.404	0.000	0.000
65 Years	0.497	0.958	1.096	1.557
66 Years	0.554	0.987	1.153	1.587
67 Years	0.595	1.028	1.194	1.628
68 Years	0.619	1.052	1.218	1.651
69 Years	0.652	1.085	1.251	1.684
70-74 Years	0.759	1.208	1.320	1.769
75-79 Years	0.955	1.357	1.430	1.832
80-84 Years	1.118	1.520	1.593	1.995
85-89 Years	1.255	1.657	1.730	2.132
90-94 Years	1.358	1.760	1.834	2.236
95 Years or Over	1.232	1.634	1.707	2.109
Male				
0-34 Years	0.344	0.675	0.000	0.000
35-44 Years	0.583	0.914	0.000	0.000
45-54 Years	0.729	1.060	0.000	0.000
55-59 Years	0.827	1.158	0.000	0.000
60-64 Years	1.033	1.365	0.000	0.000
65 Years	0.550	1.022	1.116	1.587
66 Years	0.586	1.058	1.117	1.589
67 Years	0.664	1.136	1.195	1.667
68 Years	0.664	1.136	1.195	1.667
69 Years	0.723	1.195	1.254	1.726
70-74 Years	0.855	1.322	1.392	1.859
75-79 Years	1.113	1.484	1.521	1.893
80-84 Years	1.299	1.670	1.707	2.078
85-89 Years	1.468	1.839	1.876	2.247
90-94 Years	1.630	2.001	2.038	2.409
95 Years or Over	1.638	2.009	2.046	2.417

NOTES:
The 2007 denominator of $7,463.14 used to calculate the new enrollee factors is the national predicted average annual cost under the model.

Three sets of interaction coefficients were constrained to be equal (Male, Age 67 & Male, Age 68; Medicaid, Male, Age 65 & Medicaid, Male, Ages 66 to 69; Originally Disabled, Female, Age 65 & Originally Disabled, Female, Ages 66 to 69). These constraints are necessary so that predicted expenditures, and risk scores for all demographic groups, vary in a reasonable way, as shown in the table of mutually exclusive demographic groups.

SOURCE: RTI International analysis of 2004/2005 Medicare 5% sample.

Table IV-4. Final Recalibrated Frailty Factors for CY 2009

ADL	2008 Factors (Non-Medicaid)	2009 Recalibrated Factors (Non-Medicaid)	2008 Factors (Medicaid)	2009 Recalibrated Factors (Medicaid)
0	-0.089	-0.093	-0.183	-0.180
1-2	+0.110	+0.112	+0.024	+0.035
3-4	+0.200	+0.201	+0.132	+0.155
5-6	+0.377	+0.381	+0.188	+0.200

Table IV-5. Data sources for the assignment of Medicaid status

	Payment year 2007	**Payment year 2008**	**Payment year 2009**
New enrollees	1. Third Party Buy-In file 2. Plan-reported Medicaid • Batch "01" transactions • Retroactive "01s" through IntegriGuard	1. MMA State files 2. Plan-reported • Retroactive "01s" through IntegriGuard	1. MMA State files 2. Plan-reported • Retroactive "01s" through IntegriGuard
Full risk enrollees		1. MMA State files 2. Third Party Buy-In file 3. Plan-reported Medicaid • Batch "01" transactions • Retroactive "01s" through IntegriGuard	

Notes: Full risk enrollees. CMS considers full risk Medicare beneficiaries as dually-eligible if they were eligible for title XIX during any month in the year prior to the payment year. Full risk Medicare beneficiaries have 12 months of Part B in the year prior to the payment year.
New enrollees. CMS assigns Medicaid status for new enrollees on a concurrent basis, i.e., if a newly-enrolled Medicare beneficiary is eligible for title XIX during any month during the payment year, they are considered Medicaid for that year.

Table IV-6. Acceptable diagnoses codes

Year of Payment	**Date of Service**	**Source of codes**
2007	1/06 – 12/06	The list of codes published on our website at http://www.cms.hhs.gov/MedicareAdvtgSpecRateStats/06_Risk_adjustment.asp#TopOfPage (which lists acceptable codes by year)
2008	1/07 – 12/07	The list of codes published on our website at http://www.cms.hhs.gov/MedicareAdvtgSpecRateStats/06_Risk_adjustment.asp#TopOfPage (which lists acceptable codes by year)
2009	1/08 – 12/08	Valid diagnoses in Fiscal Years 2008, 2009
2010	1/09 – 12/09	Valid diagnoses in Fiscal Years 2009, 2010
2011	1/10 – 12/10	Valid diagnoses in Fiscal Years 2010, 2011

Table IV-7. Updated Part D Benefit Parameters for Defined Standard Benefit, Low-Income Subsidy, and Retiree Drug Subsidy

Annual Percentage Increases	Annual percentage trend for 2008	Prior year revisions	Annual percentage increase for 2008
Applied to all parameters but (1)	5.97%	1.48%	7.54%
CPI (all items, U.S. city average): Applied to (1)	2.60%	0.57%	3.18%

Part D Benefit Parameters	2008	2009
Standard Benefit Design Parameters		
Deductible	$275	$295
Initial Coverage Limit	$2,510	$2,700
Out-of-Pocket Threshold	$4,050	$4,350
Total Covered Part D Drug Spend at OOP Threshold (2)	$5,726.25	$6,153.75
Minimum Cost-sharing in Catastrophic Coverage Portion of Benefit		
Generic/Preferred Multi-Source Drug	$2.25	$2.40
Other	$5.60	$6.00
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)	$1.05	$1.10
Other (3)	$3.10	$3.20
Above Out-of-Pocket Threshold	$0.00	$0.00
Over 100% FPL		
Up to Out-of-Pocket Threshold		
Generic/Preferred Multi-Source Drug	$2.25	$2.40
Other	$5.60	$6.00
Above Out-of Pocket Threshold	$0.00	$0.00
Part D Non-Full Benefit Dual Eligible Full Subsidy Parameters		
Resources ≤ $6,290 (individuals) or ≤ $9,440 (couples) (4)		
Maximum Copayments up to Out-of-Pocket Threshold		
Generic/Preferred Multi-Source Drug	$2.25	$2.40
Other	$5.60	$6.00
Maximum Copayments above Out-of-Pocket Threshold	$0.00	$0.00
Resources bet $6,290-$10,490 (ind) or $9,440-$20,970 (couples) (4)		
Deductible (3)	$56.00	$60.00
Coinsurance up to Out-of-Pocket Threshold	15%	15%
Maximum Copayments above Out-of-Pocket Threshold		
Generic/Preferred Multi-Source Drug	$2.25	$2.40
Other	$5.60	$6.00
Part D Non-Full Benefit Dual Eligible Partial Subsidy Parameters		
Deductible (3)	$56.00	$60.00
Coinsurance up to Out-of-Pocket Threshold	15%	15%
Maximum Copayments above Out-of-Pocket Threshold		
Generic/Preferred Multi-Source Drug	$2.25	$2.40
Other	$5.60	$6.00
Retiree Drug Subsidy Amounts		
Cost Threshold	$275	$295
Cost Limit	$5,600	$6,000

(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 2008 values of $55.91, $1.04, and $3.13 respectively.
(4) The actual amount of resources allowable will be updated for contract year 2009.

Office of the Actuary, Centers for Medicare and Medicaid Services, February 22, 2008