April 4, 2011

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

SUBJECT: Announcement of Calendar Year (CY) 2012 Medicare Advantage Capitation Rates and Medicare Advantage and Part D Payment Policies and Final Call Letter

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 CY 2012, and the risk and other factors to be used in adjusting such rates. The capitation rate tables for 2012 are posted on the Centers for Medicare & Medicaid Services (CMS) web site at http://www.cms.gov/MedicareAdvtgSpecRateStats/ under Ratebooks and Supporting Data. The statutory component of the regional benchmarks, transitional phase-in periods for the Affordable Care Act rates, qualifying counties, and each county's applicable percentage are also posted at this website.

Attachment I shows the final estimates of the increases in the National Per Capita MA Growth Percentages for 2012 and the national Medicare fee-for-service growth percentage. These growth rates will be used to update the 2012 rates. As discussed in Attachment I, the final estimate of the increase in the National Per Capita MA Growth Percentage for combined aged and disabled beneficiaries is -0.16 percent. Attachment II provides a set of tables that summarizes many of the key Medicare assumptions used in the calculation of the National Per Capita MA Growth Percentages.

Section 1853(b)(4) of the Act requires CMS to release county-specific per capita fee-for-service (FFS) expenditure information on an annual basis, beginning with March 1, 2001. In accordance with this requirement, FFS data for CY 2009 are being posted on the above website.

Information on deductibles for MSA plans is included below.

Attachment III presents responses to comments on the Advance Notice of Methodological Changes for CY 2011 MA Capitation Rates and Parts C and Part D Payment Policies (Advance Notice). Attachment VII presents the final Call Letter. We received 96 submissions in response to CMS' request for comments on the Advance Notice/Call Letter, published on February 18, 2011. Three of the comments were from advocacy groups, 23 were from associations, 3 were from members of the public, 2 were from states, and 65 were from health plans.

Attachment IV contains tables with the Part D benefit parameters; Attachment V contains details regarding the Part D benefit parameters; Attachment VI contains tables with the frailty, 2012 revised CMS-HCC, ESRD and Rx-HCC risk adjustment factors.

Key Changes from the Advance Notice:

National MA Growth Percentage. Attachment I provides the final estimates of the National MA Growth Percentages (growth trends) and information on deductibles for MSA.

Quality Bonus Payment Demonstration. Attachment III provides the revised Quality Bonus Payment Demonstration.

Under the demonstration the QBP percentage for each star rating will be as follows:

Stars Rating	QBP Percentage for 2012/2013	QBP Percentage for 2014
Less than 3 stars	0%	0%
3 stars	3%	3%
3.5 stars	3.5%	3.5%
4 stars	4%	5%
4.5 stars	4%	5%
5 stars	5%	5%

CMS will apply the QBP percentage to the applicable amount and the specified amount when calculating the blended benchmark and will not cap the blended rate at the level of the pre-Affordable Care Act rate for plans with 3 to 5 stars. A new MA contract offered by a parent organization that has not had any MA contract(s) with CMS in the previous three years is treated as a qualifying contract, per statute, and is assigned three stars for QBP purposes for 2012 and 2013, and 3.5 stars in 2014. These contracts are treated as new MA contracts during the demonstration until the contract has enough data to calculate a star rating. For a parent organization that has had MA contract(s) with CMS in the previous three years, any new MA contract under that parent organization will receive a weighted average of the star ratings earned by the parent organization's existing MA contracts. A low enrollment contract is a contract that could not undertake Healthcare Effectiveness Data and Information Set (HEDIS) and Health Outcome Survey (HOS) data collections because of a lack of a sufficient number of enrollees to reliably measure the performance of the health plan. For 2012, low enrollment contracts receive 3 stars for QBP purposes under the demonstration.

PACE Risk Adjustment Model. In light of the comments we received in response to our proposal to not implement a new CMS-HCC risk adjustment model, we have decided to implement the clinically updated model initially proposed in the 2011 Advance Notice for PACE organizations for 2012.

The updated model has 87 HCCs, compared to the 70 in the CMS-HCC risk adjustment model that will continue to be used for MA plan payment. The changes to the condition categories include additions, deletion, and revisions. As a result of these changes, there are additional

diagnosis codes that need to be submitted for 2012 risk scores. PACE organizations need to make certain that their systems are updated to report these additional diagnosis codes from dates of services in 2011, and should review the model software located on the CMS website at: http://www.cms.gov/MedicareAdvtgSpecRateStats/06_Risk_adjustment.asp#TopOfPage to become familiar with the new model.

Frailty Adjustment.

Attachment VI provides an update to the Frailty Adjustment factors.

In 2012, in order to determine which FIDE SNPs have levels of frailty similar to PACE and would therefore receive frailty adjusted payments in 2012 we will use the lowest score of the range of applicable PACE organization frailty scores.

Normalization. The Part D normalization factor is 1.031, rather than the 1.032 published in Advance Notice.

Update to Acceptable Physician Specialty Types for Risk Adjustment Data Submission. CMS has updated the Acceptable Physician Specialty Types for the purpose of submitting risk adjustment data. .

The updates include additions and one deletion, effective January 1, 2010. The additions are: Interventional Pain Management (IPM) (code 09), Speech Language Pathologist (code 15), Hospice and Palliative Care (code 17), and Geriatric Psychiatry (code 27). Note that Multispecialty Clinic or Group Practice (code 70) is not an Acceptable Physician Specialty Type for risk adjustment. The updated list will be posted to the CSSC Operations website to reflect these changes. www.csscoperations.com.

Part D Benefit Parameters. Attachment V provides the 2012 Part D benefit parameters for the defined standard benefit, low-income subsidy, and retiree drug subsidy. The chart has changed slightly from the version included in the Advance Notice based on a comment we received.

We are making a correction to the annual percentage increase for 2011 values in the Advance Notice. The correct value appears in Table III-1 on page 36 of the 2012 Advance Notice and is 0.98%. The value for the annual percentage increase in Table III-4 and the descriptive sentence immediately preceding the table should also be 0.98%, not 1.01%. See Attachment IV, which contains this correction.

Proposals Adopted as Issued in the Advance Notice:

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 Rate Announcement supersede materials in the Advance Notice.

Rebasing County Rates
We will rebase the FFS capitation rates for 2012.

MA Benchmark, Quality Bonus Payments and Rebate
We are implementing a number of changes in the MA payment methodology for CY 2012 as a result of payment changes enacted in the Affordable Care Act, including the following: a new blended benchmark as the MA county rate, the new methodology used to derive the new ACA blended benchmark county rates, identify the qualifying bonus counties, how to determine transitional phase-in periods, and the applicability of the star system on the rebates.

Changes to the Medicare Advantage Ratebook
We will improve the calculation of the USPCC and the AGA methodology by excluding hospice claims and cost plan data, modifying the calculation of FFS costs to account for variations in small counties, and changing the tabulation of FFS payments in Puerto Rico based on beneficiaries enrolled in both Part A and Part B.

IME Phase Out. For 2012, CMS will continue phasing out indirect medical education amounts from MA capitation rates.

Adjustment to FFS Per Capita Costs for VA-DOD Costs. We have concluded that there is sufficient evidence to warrant an adjustment to the FFS rates based on DoD data and we will be making this change.

Clinical Trials. We are continuing the policy of paying on a fee-for-service basis for qualified clinical trial items and services provided to MA plan members that are covered under the National Coverage Determinations on clinical trials.

End Stage Renal Disease (ESRD) Payment. CMS concludes the phase-in of the revised State capitation rates used to determine payments for enrollees in dialysis and transplant status in 2012. CMS will update the ESRD State capitation rates. Also, we will pay Functioning Graft enrollees based on the blended MA benchmark for the county minus the amount of any rebate dollars (if any) allocated to reduce plan enrollees' Part B premium and/or Part D basic premium, where the blended benchmark depends on the quality bonus payment (QBP) for the contract within which the person is enrolled.

Location of Network Areas for PFFS Plans in Plan Year 2013. The list of network areas for plan year 2013 is available on the CMS website at http://www.cms.hhs.gov/PrivateFeeforServicePlans/.

End of Medicare Advantage Medical Savings Account (MSA) Plan Demonstration Program.
We are not seeking an extension of the MSA Demonstration program, nor will we accept new applications.

Employer Group Waiver Plan (EGWP) Bidding. In the Advance Notice we announced our concerns about the level of EGWP bids relative to individual market bids and invited comments on ways to address our concerns. We are considering the comments that we received, but will not make any changes to EGWP bidding at this time.

CMS-HCC Risk Adjustment Model. In the Advance Notice we announced that we were not proposing to implement the new model for Part C for 2012 in order to minimize change during 2012, the first year of the blended benchmarks under the Affordable Care Act. As proposed, For all plans, except PACE plans, we are not implementing an update to the CMS-HCC Risk Adjustment model in 2012.

Recalibration of the ESRD Risk Adjustment Model. We are implementing an update to the ESRD Risk Adjustment model. The 2012 ESRD model has 87 HCCs, compared to the 70 used in the CMS-HCC risk adjustment model used prior to 2012. The changes to the condition categories include additions, deletion, and revisions. As a result of these changes, there are additional diagnosis codes that need to be submitted for 2012. MA organizations serving ESRD beneficiaries need to make certain that their systems are updated to report these additional diagnosis codes from dates of services in 2011, and should review the model software located on the CMS website at: http://www.cms.gov/MedicareAdvtgSpecRateStats/06_Risk_adjustment.asp to become familiar with the new model.

Adjustment for MA Coding Pattern Differences. We will implement an MA coding pattern difference adjustment of 3.41% for payment year 2012.

Normalization Factors. The normalization factors for 2012 are:

CMS-HCC model used for MA plans is 1.079.
CMS-HCC model used for PACE organizations is 1.051
CMS-HCC ESRD Functioning graft status is 1.051.
CMS-HCC ESRD dialysis model is 1.012.

MSP Factors. The 2012 MSP factor for ESRD beneficiaries is as follows:

ESRD dialysis/transplant: 0.189
Post-graft: 0.174

Affordable Care Act-Mandated Risk Adjustment Evaluation. CMS has published the Affordable Care Act-Mandated Risk Adjustment Evaluation at:
http://www.cms.gov/MedicareAdvtgSpecRateStats/06_Risk_adjustment.asp

Encounter Data Collection. MA Organizations and Cost plans will be required to submit encounter data beginning in 2012.

Risk Adjustment Processing System (RAPS) File Changes. Effective on January 1, 2012, CMS is modifying the format of the RAPS file in risk adjustment data collection to accommodate the implementation of coding sets using ICD-10.

Risk Adjustment Data Validation (RADV). CMS will continue conducting RADV audits and is setting forth mandatory system standards as described in the Advance Notice.

Prospective Coverage Gap Discount Program (CGDP) Payments. CMS provides monthly prospective payments to Part D sponsors for the manufacturer discounts made available to their enrollees under the CGDP. CMS will determine the monthly prospective CGDP payments for each plan by multiplying the plan-specific prospective CGDP payment amount estimated in the Part D bid by the number of non-LIS beneficiaries enrolled in the Part D plan. Consistent with the methodology proposed in the Advance Notice, no adjustment will be made to the prospective CGDP payments to reflect that manufacturer discounts under the CGDP do not include fill fees.

Cost Sharing for Non-LIS Beneficiaries in the Coverage Gap. In 2012, the coinsurance charged to eligible beneficiaries under basic prescription drug coverage for non-applicable covered Part D drugs purchased during the coverage gap phase will be 86%.

Update of the Rx-HCC Model. We will implement an update to the Part D risk adjustment model to account for the impact of the new Part D cost sharing benefit structure on LIS vs. Non-LIS beneficiaries.

DeMinimis Premium Policy. Part D sponsors may not rely on the *de minimis* premium policy to waive any part of their Part D premiums for partial subsidy or non-LIS beneficiaries.

Payment Reconciliation. The 2012 risk percentages and payment adjustments for Part D risk sharing are unchanged from contract year 2011.

Questions can be directed to:

Attachments I through VI:
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Attachments

2012 ANNOUNCEMENT
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Attachment I. Final Estimate of the Increase in the National Per Capita MA Growth Percentages and the National Medicare Fee-for-Service Growth Percentage for 2012

The Table 1 below shows the National Per Capita MA Growth Percentages (NPCMAGP) for 2012. An adjustments of 0.59 percent for the combined aged and disabled is 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. Since a new ESRD model based on 2009 data is being used, the NPCMAGP shown for ESRD below is the current trend from 2009 to 2012.

Table 1 - Increase in the National Per Capita MA Growth Percentages for 2012

	Prior Increases	Current Increases			NPCMAGP for 2012 With §1853(c)(6)(C) adjustment[1]
	2003 to 2010	2003 to 2010	2010 to 2012	2003 to 2012	
Aged+Disabled	41.07%	41.91%	−0.75%	40.84%	−0.16%
ESRD[2]	N/A	2.83% [3]	3.29%	6.21% [4]	6.21% [4]

[1]Current increases for 2003 to 2012 divided by the prior increases for 2003 to 2010 (Aged+Disabled only).
[2]Increases for ESRD reflect an estimate of the increase for dialysis-only beneficiaries.
[3]Current increase for 2010 only.
[4]Reflects 3-year increase from 2009 to 2012.

The Affordable Care Act of 2010 requires the Medicare Advantage benchmark amounts be tied to a percentage of the county FFS amounts. There will be a transition to the percentage of FFS over a number of years. Table 2 below provides the increase in the FFS USPCC which will be used for the county FFS portion of the benchmark. The percentage increase in the FFS USPCC is shown as the current projected FFS USPCC for 2012 divided by projected FFS USPCC for 2010 as estimated in the 2010 Rate Announcement released on April 6, 2009.

Table 2 – Increase in the FFS USPCC Growth Percentage

Current projected 2012 FFS USPCC	$743.54
Prior projected 2010 FFS USPCC	$741.89
Percent increase	0.22%

Table 3 below shows the monthly actuarial value of the Medicare deductible and coinsurance for 2010 and 2012. In addition, for 2012, the actuarial value of deductibles and coinsurance is being shown for non-ESRD only, since the plan bids will not include ESRD benefits in 2012. These data were furnished by the Office of the Actuary.

Table 3 - Monthly Actuarial Value of Medicare Deductible and Coinsurance for 2010 and 2012

	2010	2012	Change	2012 non-ESRD
Part A Benefits	$40.31	$40.92	1.5%	$38.93
Part B Benefits[1]	$100.01	$100.20	0.2%	$92.90
Total Medicare	$140.32	$141.12	0.6%	$131.83

[1]Includes the amounts for outpatient psychiatric charges.

Medical Savings Account (MSA) Plans. The maximum deductible for current law MSA plans for 2012 is $10,600.

Attachment II. Key Assumptions and Financial Information

The USPCCs are the basis for the National Per Capita MA Growth Percentages. Attached is a table that compares the published United States Per Capita Costs (USPCC) with current estimates for 2003 to 2012. In addition, this table shows the current projections of the USPCCs through 2014. We are also providing an attached set of tables that summarizes many of the key Medicare assumptions used in the calculation of the USPCCs. Most of the tables include information for the years 2003 through 2014.

Previously, most of the tables in this attachment showed information for aged and disabled non-ESRD separately. Since the MA payment rates are now exclusively based on combined aged and disabled data, we are showing most information on a combined basis. The ESRD information presented is for the combined aged-ESRD, disabled-ESRD and ESRD only.

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 – non-ESRD

Calendar Year	Part A			Part B			Part A & Part B		
	Current Estimate	Published Estimate	Ratio	Current Estimate	Published Estimate	Ratio	Current Estimate	Published Estimate	Ratio
2003	294.35	282.50	0.960	249.42	229.47	0.920	543.77	511.97	0.942
2004	312.39	318.43	1.019	274.13	261.89	0.955	586.52	580.32	0.989
2005	332.45	339.49	1.021	293.62	280.58	0.956	626.07	620.07	0.990
2006	343.81	342.67	0.997	314.53	312.09	0.992	658.34	654.76	0.995
2007	354.60	362.06	1.021	332.39	335.47	1.009	686.99	697.53	1..015
2008	371.61	379.02	1.020	353.03	352.75	0.999	724.64	731.77	1.010
2009	386.14	408.50	1.058	370.50	357.89	0.966	756.64	766.39	1.013
2010	393.94	407.38	1.034	377.71	360.25	0.954	771.65	767.63	0.995
2011	399.73	407.38	1.019	391.25	360.25	0.921	790.98	767.63	0.970
2012	402.32	402.32	1.000	363.54	363.54	1.000	765.86	765.86	1.000
2013	405.84	—	—	374.95	—	—	780.79	—	—
2014	410.94	—	—	392.22	—	—	803.16	—	—

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

PART A:

Calendar Year	All ESRD				Basis for Growth Percentage	
	Current Estimate	Published Estimate	Ratio	Current Cumulative Trend	Adjustment Factor for Dialysis-only	Adjusted Current Cumulative Trend
2009	2240.55	1885.71	0.842			
2010	2326.46	2133.76	0.917	1.0383	1.0018	1.0402
2011	2364.76	2133.76	0.902	1.0554	1.0036	1.0592
2012	2415.74	2415.74	1.000	1.0782	1.0054	1.0840
2013	2451.51	—	—	1.0942	1.0072	1.1021
2014	2489.49	—	—	1.1111	1.0090	1.1211

PART B:

Calendar Year	All ESRD				Basis for Growth Percentage	
	Current Estimate	Published Estimate	Ratio	Current Cumulative Trend	Adjustment Factor for Dialysis-only	Adjusted Current Cumulative Trend
2009	2679.76	2371.73	0.885			
2010	2668.11	2523.56	0.946	0.9957	1.0227	1.0183
2011	2677.69	2523.56	0.942	0.9992	1.0459	1.0451
2012	2614.84	2614.84	1.000	0.9758	1.0697	1.0437
2013	2698.10	—	—	1.0068	1.0939	1.1014
2014	2928.32	—	—	1.0928	1.1188	1.2225

PART A & PART B:

Calendar Year	All ESRD				Basis for Growth Percentage	
	Current Estimate	Published Estimate	Ratio	Current Cumulative Trend	Adjustment Factor for Dialysis-only	Adjusted Current Cumulative Trend
2009	4920.31	4257.44	0.865			
2010	4994.57	4657.32	0.932	1.0151	1.0130	1.0283
2011	5042.45	4657.32	0.924	1.0248	1.0261	1.0515
2012	5030.58	5030.58	1.000	1.0224	1.0388	1.0621
2013	5149.61	—	—	1.0466	1.0527	1.1017
2014	5417.81	—	—	1.1011	1.0683	1.1764

Summary of Key Projections under Present Law [1]

Part A

Year	Calendar Year CPI Percent Increase	Fiscal Year PPS Update Factor	FY Part A Total Reimbursement (Incurred)
2003	2.2	3.0	3.6
2004	2.6	3.4	8.6
2005	3.5	3.3	8.6
2006	3.2	3.7	6.2
2007	2.9	3.4	5.8
2008	4.1	3.3	7.6
2009	−0.7	2.7	7.3
2010	2.1	1.9	4.8
2011	1.2	−0.6	4.2
2012	1.7	1.9	4.9
2013	1.9	1.4	4.3
2014	2.0	2.3	5.0

Part B[2]

	Physician Fee Schedule			
Calendar Year	Fees	Residual[3]	Part B Hospital	Total
2003	1.4	4.5%	4.4%	6.8%
2004	1.8	5.9%	11.0%	9.8%
2005	1.5	3.2%	10.6%	7.0%
2006	0.2	4.6%	5.1%	6.1%
2007	0.0	3.5%	8.1%	4.3%
2008	0.5	3.3%	6.4%	4.8%
2009	1.1	2.1%	8.7%	3.8%
2010	1.3	1.0%	5.0%	2.0%
2011	0.9	4.4%	6.7%	3.6%
2012	−29.4	8.2%	5.8%	−7.6%
2013	−0.3	3.2%	6.5%	3.6%
2014	1.3	3.5%	6.5%	5.4%

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

Medicare Enrollment Projections under Present Law (In Millions)

Non-ESRD

	Part A		Part B	
Calendar Year	Aged	Disabled	Aged	Disabled
2003	34.426	5.929	33.027	5.187
2004	34.837	6.248	33.282	5.458
2005	35.243	6.574	33.608	5.746
2006	35.780	6.851	33.960	5.986
2007	36.430	7.128	34.449	6.212
2008	37.359	7.321	35.122	6.404
2009	38.236	7.496	35.793	6.620
2010	38.975	7.655	36.467	6.866
2011	39.847	8.175	37.316	7.281
2012	41.179	8.498	38.476	7.588
2013	42.628	8.810	39.781	7.853
2014	44.034	9.001	41.030	8.028

ESRD

Calendar Year	Total Part A	Total Part B
2003	0.382	0.370
2004	0.399	0.382
2005	0.416	0.398
2006	0.435	0.415
2007	0.452	0.432
2008	0.470	0.449
2009	0.487	0.466
2010	0.504	0.483
2011	0.527	0.505
2012	0.548	0.526
2013	0.568	0.545
2014	0.584	0.561

Part A Projections under Present Law for non-ESRD (Aged+Disabled) [1]

Calendar Year	Inpatient Hospital Aged + Disabled	SNF Aged + Disabled	Home Health Aged + Disabled	Managed Care Aged + Disabled	Hospice: Total Reimbursement (in Millions) Aged + Disabled
2003	2,571.52	371.33	124.41	458.36	5,733
2004	2,692.59	414.46	134.04	501.30	6,832
2005	2,787.71	451.64	141.04	603.00	8,016
2006	2,743.52	476.99	141.92	758.13	9,341
2007	2,693.59	505.57	144.35	907.53	10,477
2008	2,689.15	537.35	149.39	1,079.18	11,347
2009	2,670.91	553.97	152.50	1,252.42	12,210
2010	2,734.78	571.66	153.81	1,261.43	13,156
2011	2,733.29	590.69	148.80	1,318.30	14,164
2012	2,806.28	614.08	148.78	1,253.04	15,203
2013	2,899.72	640.38	154.67	1,169.76	16,128
2014	3,028.86	670.73	158.07	1,067.93	17,028

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

Part B Projections under Present Law for non-ESRD (Aged+Disabled) [1]

Calendar Year	Physician Fee Schedule Aged + Disabled	Part B Hospital Aged + Disabled	Durable Medicare Equipment Aged + Disabled
2003	1240.44	378.70	197.68
2004	1367.31	433.70	198.34
2005	1404.38	493.22	196.40
2006	1403.32	513.10	197.88
2007	1381.45	542.45	195.83
2008	1380.96	571.66	201.29
2009	1401.39	617.17	181.21
2010	1439.78	644.68	179.47
2011	1481.74	686.25	184.30
2012	1096.02	738.80	196.29
2013	1147.89	810.03	195.09
2014	1245.06	894.09	211.29

Calendar Year	Carrier Lab Aged + Disabled	Other Carrier Aged + Disabled	Intermediary Lab Aged + Disabled
2003	74.78	333.74	61.72
2004	80.61	361.00	66.14
2005	82.56	363.88	69.24
2006	85.44	362.10	69.57
2007	91.42	367.23	69.55
2008	95.26	370.44	70.27
2009	103.68	377.38	74.94
2010	105.01	373.18	76.14
2011	109.17	380.27	77.17
2012	115.25	398.63	78.09
2013	123.10	424.41	82.13
2014	131.96	455.92	87.17

Calendar Year	Other Intermediary Aged + Disabled	Home Health Aged + Disabled	Managed Care Aged + Disabled
2003	114.10	136.89	421.83
2004	119.70	156.61	471.86
2005	139.93	179.63	560.92
2006	142.25	203.11	770.82
2007	151.19	232.85	932.61
2008	158.37	252.97	1,108.18
2009	176.69	279.29	1,210.17
2010	181.34	281.28	1,228.80
2011	193.06	272.79	1,286.60
2012	181.69	273.42	1,262.40
2013	199.29	284.65	1,210.13
2014	219.73	291.10	1,146.03

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

Claims Processing Costs as a Fraction of Benefits

Calendar Year	Part A	Part B
2003	0.001849	0.011194
2004	0.001676	0.010542
2005	0.001515	0.009540
2006	0.001245	0.007126
2007	0.000968	0.006067
2008	0.000944	0.006414
2009	0.000844	0.005455
2010	0.000773	0.005055
2011	0.000773	0.005055
2012	0.000773	0.005055
2013	0.000773	0.005055
2014	0.000773	0.005055

Approximate Calculation of the USPCC and the National MA Growth Percentage for Combined (Aged+Disabled) 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 can be approximated by using the assumptions in the tables titled "Part A Projections Under Present Law for non-ESRD (Aged+Disabled)" 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 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.

Part B:

The Part B USPCC can be approximated by using the assumptions in the tables titled "Part B Projections under Present Law for non-ESRD (Aged+Disabled)" 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 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.

The National Per Capita MA Growth Percentage:

The National Per Capita MA Growth Percentage for 2012 (before adjustment for prior years' over/under estimates) is calculated by adding the USPCCs for Part A and Part B for 2012 and then dividing by the sum of the current estimates of the USPCCs for Part A and Part B for 2010.

Attachment III. Responses to Public Comments

Section A. Estimate of the National Per Capita MA Growth Percentage for Calendar Year 2012

Comment: Commenters requested more detail and documentation regarding how the growth percentage was calculated for the Advance Notice, including the basis for CMS' estimate. Commenters asked that CMS include key assumptions underlying the estimate, information on revisions to prior year estimates as shown in Table I of the Advance Notice, and fee schedule and utilization trend assumptions by categories of service (as is typically shown in Attachment II of the Announcement). Commenters also requested that CMS place more documentation in the Advance Notices for future years to assist organizations in understanding the growth percentage.

Response: We will consider providing more detailed information in the Advance Notice to assist in understanding the preliminary estimate of the growth percentage. Regarding the year-by-year revisions to prior year estimates, we believe the final Announcement already has sufficient information to do such calculations. One can compare the USPCCs in Attachment II in the prior Announcement with the current Announcement to see how the year-by-year increases have changed.

The national Medicare fee-for-service growth percentage is used to calculate the FFS rates. CMS has not previously included an estimate of the fee-for-service growth percentage in the Advance Notice. We have, however, decided to do so for 2012 and future years because of the importance of the FFS rates in the calculation of the blended benchmarks.

Comment: One commenter asserted that CMS has consistently understated the MA growth percentage in its annual announcements, on average by approximately 1.5 percentage points. The commenter is concerned that this is not driven by the physician fee cut issue and that there may be a bias in CMS' estimation methodologies that needs to be addressed.

Response: Looking back at the original growth percentage estimates for each year from 2004 to 2010 compared to the current estimates for those years, the original estimates are on average 1% - 1.5 % lower. However, the original estimates included the physician update cuts before they were overridden by subsequent fixes by Congress. The current estimates reflect the actual payment rates. If the original estimates were adjusted to reflect the eventual overrides for those years, the comparison would be more favorable and would indicate no particular bias in CMS' estimation methodologies.

Comment: Two commenters stated that the estimates for the 2010-2012 growth rate (2.5-3%) are significantly lower than historical actual growth rates, which average about 6%. The commenters asked that CMS explain the drivers for the trend deceleration for 2010-2012.

Response: Current estimates for the growth rates for 2006 through 2009 average about 5%. Impacts of the Affordable Care Act (ACA) start in 2010 and 2011, which is holding down the increase in those years. In addition, for FY 2011, there is some recoupment of excess coding and documentation under the MS-DRG system for hospital services. For 2012, in addition to continued ACA cuts, the current estimate reflects the almost 30 percent cut in the physician update.

Comment: Commenters asked for a detailed explanation of the projected restatements of prior year estimates of the MA growth rate back to 2004 in order to better understand the current growth rate. The commenter requested that going forward, this information be included in the Advance Notice as well as the Announcement. Commenters asked for information about the impact of physician fee cuts, the medical inflationary trend, and the ACA.

Response: There is sufficient detail presented in each year's Announcement to describe the major reasons for change in prior year's estimates. As previously stated, we will consider presenting more detailed information in the Advance Notice as well.

The growth percentages can change for several years back. In the current restatement, we don't believe that the revised estimates are materially different for 2004 through 2007. In fact, in the preliminary estimate, two of those years had slightly negative adjustments and two were slightly positive. There generally isn't any particular bias in the adjustments for prior years.

For the more recent years, there can be significant changes to the prior years. The last Announcement that contained rate information was released in April of 2009. The data used in the baseline projections at that time was data reported through the middle of 2008. Hence, it is not surprising to experience significant changes to the 2008 and later growth rates. What we have seen in the data reported since the middle of 2008 is that Part A inpatient hospital admissions and real case mix were down for 2008 and 2009 compared to what was previously assumed. This explains most of the change for those two years.

In the 2010 Announcement, the previous growth factors assumed the approximate 20% cut in the physician update, whereas the current estimate for 2010 reflects the actual payment rates. Hence, there is a large positive adjustment. Included in the adjustment for 2010 as a partial offset are the initial impacts of the ACA implementation. There are some ACA provisions which increase spending, but they are outweighed by the provisions which reduce spending.

The prior year's adjustment for 2011 is the same as the current trend, since the effective update for 2011 MA payment rates was 0 percent due to the provision in the ACA which froze MA payment rates for the year. The current trend reflects a 0 percent update for physician payments as well as other currently scheduled updates for FFS providers. Included in this trend are further cuts in FFS provider payment rates provided for by the ACA, other ACA provisions, and some recoupment of excess coding and documentation in the MS-DRG system for inpatient hospital payments in FY 2011.

For 2012, the large negative trend reflects the assumed almost 29.5% cut in the physician update.

Comment: One commenter asked that CMS provide the assumptions underlying the estimates of the USPCC.

Response: Attachment II of this Notice provides the major underlying economic, demographic and health assumptions used in the development of the USPCC. In addition, per capita amounts by type of service are shown in the attachment.

Comment: One commenter noted that Table I-2 shows the national per capita MA growth percentage for ESRD back to 2010 and asked for data from prior years. The commenter also asked CMS to explain the low ESRD trend in 2012 of .94%.

Response: Since the ESRD ratebook has been updated to a 2009 base, the trends prior to 2009 are no longer relevant. The updated data for 2009 implicitly includes adjustments for prior years.

Since the bulk of ESRD expenditures is for dialysis services, and dialysis services are not heavily physician expenditures, the large negative physician update for 2012 does not play as big a role as it does for non-ESRD expenditures. Therefore, there is a small positive trend as opposed to the negative trend estimated for non-ESRD expenditures.

Comment: Several commenters contended that, given the fact that Congress since 2003 has made adjustments to avoid reductions in physician payments under the SGR formula, it can be expected that Congress will again act legislatively to eliminate the reduction in payment for 2012 provided for under current law. These commenters accordingly requested that CMS include the impact of the expected SGR "fix" when calculating the national per capita MA growth percentage and prior year revision. Commenters recommended that CMS disclose the legislative and/or regulatory basis that requires it to ignore the consistent repeal of the SGR-legislated fee schedule reductions. One commenter noted that the policy is especially problematic for PFFS plans.

Response: CMS's consistent interpretation and longstanding practice has been to base the projected growth percentage on the law as it exists on the date of the announcement of the payment rate update. The statute requires that the growth percentage reflect the Secretary's estimate of the projected per capita rate of growth in expenditures "under this title." We believe that the best reading of this statutory language is that the growth percentage should be based on the provisions of "this title" (Title XVIII) as of the date that the rates are announced. As a result, every ratebook to date has been based on a USPCC increase estimated under the then current law. Changes to the Medicare statute are a fairly common occurrence. There have been a number of years where Medicare expenditures were expected to be reduced by pending legislative action. In those years, if we had anticipated the legislative changes in the projections, payments to Medicare Advantage plans would have been reduced. By following current law as the basis for

the projection, any judgment regarding the likelihood or implications of unknown possible law changes is removed.

Comment: Commenters noted that the President's Budget Proposal proposes funding for a two year fix to the cut in physician rates and that it assumes that a permanent fix will be found. Commenters assert that the growth percentage and Part C rates should be based on identical assumptions.

Response: While the President's Budget Proposal may "reflect the Administration's best estimate of future Congressional action based on what the Congress has done in recent years for physician payments," it is still a proposal, not law. CMS's policy is still that the growth rate increases reflect current law. The Administration remains committed to a permanent, fiscally responsible, solution to the Medicare physician payment system. A permanent solution would improve payment rates for MA plans as well as physicians in the future. If such a solution – or even a temporary extension to prevent a payment cut in 2012 -- could be enacted early this year, it could affect MA rates for 2012.

Section B. MA Benchmark, Quality Bonus Payments and Rebate

Comment: One commenter requested clarification on how the rates will be calculated and applied to Regional Plans.

Response: We appreciate the opportunity to clarify this policy. The 2012 regional rates will continue to be a blend of a plan bid component and a regional benchmark. There will be regional benchmarks for each appropriate level of star rating (e.g., less than 3 stars, 3 stars, 3.5 stars, etc.), and these regional benchmarks will be blended with the plan bid component to determine the regional rate. These two components will then be weighted together by the percentage of Medicare beneficiaries enrolled in Fee-for-Service (FFS) vs. Medicare Advantage (MA) plans nationwide to determine the 2012 rate.

Comment: One commenter inquired as to whether the status of a qualifying county will be reflected in the ratebook or if plans will need to make an adjustment in their bids to account for the extra revenue.

Response: The ratebook contains multiple rates for each county so that the appropriate rate for each plan within a county will be applied to that plan based both on the plan's star rating and status as a qualifying county.

Comment: One commenter requested confirmation that the star ratings in effect for 2011 will be the basis for determining 2012 quality bonus percentages.

Response: The commenter's assumptions are correct. The star rating assigned in 2011 will be the star rating used to determine the 2012 quality bonus percentage.

Comment: A number of commenters commended CMS for providing MA organizations the relevant and important data for determining which qualifying counties would receive double quality bonus payments, applicable phase-down periods, and the county quartile percentages.

Response: We appreciate the support for having published this information.

Comment: Several commenters requested that CMS clarify the methodology under which the national average Fee-For-Service Amount will be determined, while one other commenter expressed difficulty in recreating the methodology used by CMS to divide counties into quartiles and requested that CMS publish additional details on these calculations.

Response: The quartiles were determined based on the published 2009 FFS county rates, where the territories were excluded from the determination of the quartile cutpoints. The details on the methodology and calculations used for determining county quartiles as well as the other figures used to determine the national fee for service average can be found in the risk2012.csv file in the rate calculation data files posted on the CMS website. Details regarding the National Medicare Fee-for-Service Growth Percentage are in Attachment I.

Comment: Several commenters requested that CMS provide a written confirmation that the new blended benchmarks being implemented in accordance with the Affordable Care Act will not be applied as the MA county rate applied to PACE organizations.

Response: We welcome the opportunity to clarify this issue. The blended benchmarks will not be used as the MA county rates applied to the payment to PACE organizations. The PACE rates will be published in a separate ratebook.

Comment: One commenter asked CMS to specify how the amount of rebate for new plans under existing parent organizations would be determined and recommended that the determination be made in the same manner that the quality bonus percentage is specified for such plans.

Response: CMS has described how the amount of rebate would be determined for plans, including new plans in the proposed regulation proposed in response to the ACA in November 2010. New contracts offered by existing parent organizations will receive a star rating based on the star rating of all plans offered by the parent organization. The rebate percentages, and quality bonus percentages, are based on this star rating.

Comment: Many commenters offered support for the Quality Bonus Payment Demonstration asserting that the demonstration is an appropriate transition to an incentive-based payment system that rewards MA plans for achieving meaningful quality-based goals. These commenters set forth their belief that it is important that plans be evaluated on their ability to meet benchmarks established well in advance of the payment year to which quality based payments are applied, and the three year demonstration gives them an opportunity to use the resources gained from the demonstration on quality improvement. A number of commenters also

expressed their support for expanding this demonstration to stand-alone prescription drug plans in the future.

We received a number of comments on possible revisions to the demonstration. Several commenters contended that rewards to high quality plans should be more significant. One commenter recommended that CMS consider modifying the demonstration to recognize the investment plans have made without financial incentives to improve their quality and customer satisfaction, suggesting that CMS reduce the payments to 3 and 3.5 star plans and to increase quality bonus payments to plans with a star rating of 4 or higher. Another commenter recommended enhancing the bonus amount between 4 and 4.5 star plans to provide increased incentive to achieve the higher rating if the 5 star appears too difficult, also suggesting that enhanced bonus dollars could be given to those plans consistently achieving a 5 star rating. A few commenters believe it is not necessary to extend the quality bonus payment percentages to the entire blended county rate for plans with fewer than 5 stars, and that the benchmarks for the 3 to 4.5 star plans should not exceed the caps established in the ACA. A few commenters also suggested that CMS consider also rewarding plans that demonstrate significant incremental improvements in quality performance year over year to further incentivize plans to continue to develop programs to improve quality.

One commenter recommended non-payment rewards for high quality plans. This commenter recommended permitting a special election period for plans with a 4.5 star rating in those states where no plan achieves a 5 star rating.

Another commenter expressed concern that the demonstration design appears to leave plans that serve low income and under-educated service areas at a disadvantage.

A number of other commenters were concerned about the transition from the demonstration to the statutory requirements. Commenters recommended that CMS either extend the demonstration or create a five or six year transition from the demonstration to current law to provide plans additional time to improve their quality ratings and prevent sizeable reductions in bonus payments the year after the demonstration concludes. Some commenters asserted that the demonstration is a time-limited, transitional program quite adequate to allow plans to adjust to the payment system envisioned under the ACA, and a longer term demonstration policy could encourage plans to become complacent once they obtain a three star quality rating.

Response: We appreciate the support and have taken these comments into consideration in revising the demonstration. Due to the general support we have received for the demonstration, and the request that we recognize and reward high quality plans, we will modify the demonstration design to further incent more rapid and larger year-to-year quality improvement. The revised demonstration is intended to further increase the incentive for plans to improve their quality star ratings. CMS will apply the QBP percentage to both the applicable amount and the specified amount when calculating the blended benchmark and will not cap the blended rate at

the level of the pre-Affordable Care Act rate for plans with 3 to 5 stars. This nationwide three-year demonstration will be in effect from 2012 to 2014.

Under the demonstration the QBP percentage for each star rating will be as follows:

Stars Rating	QBP Percentage for 2012/2013	QBP Percentage for 2014
Less than 3 stars	0%	0%
3 stars	3%	3%
3.5 stars	3.5%	3.5%
4 stars	4%	5%
4.5 stars	4%	5%
5 stars	5%	5%

The design of the demonstration is intended to provide a strong incentive to improve performance at every star rating level, and to provide additional time for plans to achieve quality improvement. The three year duration was established in recognition of the multi-year time lag between the contract year measured for quality and payment year. An evaluation of the demonstration will be performed at its conclusion to determine how effective it was to incentivize increased quality on a national basis, and as a learning tool to see what other incentives may be more useful and productive in the future.

Comment: One commenter requested CMS clarify whether the qualifying county bonus payments would also be added to the entire blended benchmark under the demonstration.

Response: The revised demonstration applies the quality bonus percentage to each part of the blended benchmark. Specifically, the Applicable Amount is determined by establishing the appropriate pre-ACA county rate and multiplying that amount by the specific transition blend percentage for that county, the product of which is then multiplied by the (1 + plan specific quality bonus percentage). To establish the Specified Amount, the appropriate county fee for service transition blend percentage is multiplied by the sum of the Applicable Percentage and the plan specific quality bonus percentage, the product of which is then multiplied by the county appropriate fee-for-service rate. The Applicable Amount is then added to the Specified Amount to establish the final county rate to be applied.

The formula would therefore appear as follows: [(county specific transition blend percentage × pre-ACA county rate) × (1 + plan specific quality bonus percentage)] + [county specific fee-for-service transition blend percentage × (applicable percentage + plan specific quality bonus percentage) × county FFS rate] = final rate.

More details on the calculation of the rates can be found in the risk2012.csv file in the rate calculation data files posted on the CMS website.

Comment: A number of commenters expressed their support for applying the quality bonus percentages to the entire blended county rate for 3-4.5 star plans.

Response: We appreciate the support and have taken these comments into consideration in revising the demonstration. CMS will apply the QBP percentage to the entire 2012 blended county rate for plans with 3 to 5 stars. More specifically, we will apply the QBP percentage to both the applicable amount and the specified amount.

Comment: A number of commenters that expressed support for the quality bonus demonstration also declared that they do not support the imposition of caps on the benchmarks, stating their belief that if the caps were applied it would defeat the purpose of the demonstration. Another commenter suggested that if the ACA caps were to be applied their application should be based on a sliding scale with the lowest cap being on 3 star plans and no cap on the 4.5 and 5 star plans.

Response: We appreciate these comments and have taken them into consideration in revising the demonstration. We agree that caps would inhibit more rapid and larger year-to-year quality improvements in quality scores, because in some cases the benchmark would be capped before the bonus payment for quality would apply. Therefore, CMS will not cap the blended rate at the level of the pre-affordable Care Act rate for plans with 3 to 5 stars.

Comment: A number of commenters felt that the quality bonus percentage demonstration should allow for special provisions for specific types of plans like PACE and SNPs because of the special populations and quality issues they experience, and the special quality standards they must meet in order to qualify to become one of these specialized plans. A few other commenters also felt that the demonstration should be applied to Puerto Rico differently from the mainland such that Puerto Rican star ratings should be compared to other plans on the island rather than nationally for the duration of the demonstration, and that an exception to the ACA rule requiring a county to have been a rural floor county in 2004 should be made in determining qualifying counties to receive double bonus payments in Puerto Rico as Puerto Rican counties were precluded from receiving rural floor payments because of a territorial exception in the law which limited payment rate increases to 20% above the payment rates for the previous year.

Response: We appreciate these comments and have taken them into consideration in revising the demonstration. The purpose of the demonstration is to test whether using a scaled approach that makes quality bonus percentages available to additional rating levels instead of the current law two-level rule (four and five star plans) leads to more rapid and larger program-wide increases in plan quality scores during the three-year period of the demonstration. In light of the fact that the demonstration is being conducted nationwide and that all MA plans are participating in the demonstration, carving out special provisions for each plan type and population would have been contrary to CMS's intent to provide a strong incentive for all plans to improve performance and quality at every star rating level. We also note that at this point PACE organizations do not receive star ratings and they will be paid the pre-ACA rate.

Comment: Two commenters disagreed with CMS's proposal to implement the same rules for use of rebate dollars for 2012 that applied for 2011, under which MA organizations could continue to use rebate dollars only for the purposes set forth in section 1854(b)(1)(C)(ii), and one questioned CMS's authority to adopt this limitation given the fact that the statutory language containing these limitations was no longer in place for 2012, and suggested that at a minimum CMS should go through rulemaking to adopt this policy in regulations..

Response: First, as to the substance of our proposal to impose the limitations` at issue, we recognize that the statutory language setting forth these limitations is no longer in place for 2012, and were not relying on this inapplicable language in our proposal. Rather, we proposed, as part of the Advance Notice process, that rebate dollars continue to be used in one of the three ways that were specified in this language. We believe this approach provides MA organizations with more flexibility than would have been provided for 2012 under the statutory provision enacted on March 23, 2010 that was subsequently repealed in the reconciliation bill, while continuing to ensure that rebate dollars were used for appropriate, MA plan-related purposes. It is not clear what uses of rebate dollars the commenters contemplate other than providing additional plan benefits, buying down cost-sharing, or buying down premiums, including Part B premiums. This last option is tantamount to providing cash to enrollees, as a smaller amount is deducted from Social Security checks.

With respect to the procedural issue of how we are implementing this proposal, section 1853(b)(2) provides that CMS "shall provide for notice to [MA] organizations of proposed changes to be made in the methodology. . .used in previous [year] and shall provide [MA] organizations an opportunity to comment on such proposed changes." Section 1853(b)(1), in turn, provides for a final notice in which the "risk and other factors to be used in adjusting" payment will be published. This notice and comment process has been in place with respect to payment issues since 1985, when CMS first began contracting with private health plans on a capitation basis, under procedures set forth in section 1876(a)(1)(F) of the Act that are identical to those in section 1853(b)(2). All major changes in payment policy have been implemented through this process. For example, when section 1853(a)(3) was first implemented in 2000 with the initial risk adjustment methodology developed by CMS, this initial methodology was implemented through this section 1853(b) notice and comment process. All subsequent changes to the risk adjustment methodology, including the establishment of a "budget neutrality factor" to make risk adjustment budget neutral, and the subsequent decision by CMS to phase out budget neutrality (which was ratified by Congress in the DRA) have all been implemented through the section 1853(b) notice process. Other changes involving MA payment have been implemented through this process as well. Given that Congress specifically provided for this approach in the case of changes involving MA payment, Congress was specifying that this process was to be used to implement such changes, and that in its judgment this process gives MA organization a sufficient opportunity for input on changes affecting their payments. This belief is buttressed by the fact that Congress has on several occasions ratified in statute methodologies that CMS

established through this 1853(b) process (e.g., the initial phase in of risk adjustment and the plan to phase out budget neutrality). Because of the time needed to respond to plan comments, and prepare the notice by the 45 day deadline established by Congress, CMS has historically allowed a two-week comment period on proposed changes discussed in the Advance Notice.

Section C. Changes to the Medicare Advantage Ratebook

Comment: Several commenters noted that CMS uses a 2,000 member threshold to reflect a credibility theory for calculating FFS costs that contribute to the AGA factor and recommended that CMS consider using this same 2,000 member threshold member for the proposed small county adjustment.

Response: In the instructions for developing the bid pricing tools, CMS establishes a guideline for full credibility for MA plans of 24,000 base period member months or roughly 2,000 members. This standard is applied against one year of plan experience. In developing the Average Geographic Adjusters (AGA), five years of FFS data is used. Using five years of data requires fewer members to be considered fully credible than using one year. We studied the impact of using different levels of full credibility and determined that using 1,000 members significantly reduced the severity of fluctuations in the FFS rate development attributable to counties with low enrollment. CMS will use a 1,000 member threshold for the small county adjustment.

Comment: One commenter expressed concern about the proposed exclusion of Hospice claims for beneficiaries in Hospice status from the FFS costs used in the calculation of the AGA, stating that doing so would create two separate FFS amounts, and questioned the agency's authority for making this change.

Response: The development of the FFS USPCC has excluded Hospice claims since rates were developed on an adjusted average per capita cost basis. Excluding claims for beneficiaries in Hospice status from the AGA calculation aligns the calculation of the AGAs with how they are applied.

Comment: Several commenters felt that a delay in applying these changes to Puerto Rico rates is unnecessary, and CMS should not phase-in any changes resulting from a change in the methodology. Several commenters requested additional information regarding the data, time periods, assumptions and calculations used to produce the Puerto Rico adjustment. One commenter asserted that the proposed adjustment is not enough.

Response: We appreciate the effort and amount of detail submitted by the commenters on this issue. CMS conducted a detailed analysis of the FFS costs in Puerto Rico to ascertain the impact of the unique characteristics of beneficiaries in Puerto Rico before proposing an adjustment to the methodology used to calculate the Puerto Rico rates. As described in the Advance Notice, we tabulated the 2009 FFS costs in Puerto Rico for the cohort of Part A and/or Part B

beneficiaries as well as for beneficiaries enrolled in both Part A and Part B. We identified that the per capita costs for beneficiaries enrolled in both Part A and Part B were higher than those enrolled in Part A and/or Part B for all counties with Part B FFS enrollment of at least 100 members and most counties with less than 100 members. Medicare enrollment, cost and use in Puerto Rico is different than in the states. A far greater proportion of beneficiaries enroll in Medicare Advantage plans (67% in Puerto Rico vs 24% nationally) and those that do remain in fee-for-service are much less likely to enroll in Part B (46% in Puerto Rico vs 91% nationally). While most mainland beneficiaries are automatically enrolled in Part B, and must opt out to decline it, Puerto Rican beneficiaries are required to opt-in to Part B coverage. In addition, Medicare fee-for-service payment rates tend to be lower. Given these differences, we believe that establishing the FFS rate in Puerto Rico based on enrollees in both Part A and Part B is a reasonable approach. As with the other the other changes that affect the AGA calculation and to limit significant annual fluctuations, either upward or downward, we will reflect the new approach for tabulating FFS claims and enrollees beginning with the 2009 FFS tabulation. We have revised our estimate of the impact. This change will result in an average increase of .4% in the blended benchmark for Puerto Rico counties in 2012.

Comment: One commenter suggested that the calculation of the AGA be modified to increase the weight of expenditure data for the latest years used in this calculation instead of weighting them equally in determining the 2012 county rates.

Response: While we are concerned that introducing a new data with greater weight may introduce additional volatility into the AGA calculation, we will consider this comment in the development of future AGAs.

Comment: One commenter requested that CMS evaluate the impact on the Minnesota market place before implementing a change to the way Cost Plan claims are treated in the FFS cost calculations.

Response: We appreciate the commenter's concerns, however, CMS conducted a detailed analysis on the impact of implementing this adjustment on all counties before proposing this adjustment to the methodology. As with the other changes that affect the AGA calculation and to limit significant annual fluctuations, either upward or downward, we will reflect the new approach of excluding all FFS claims for Cost Plan enrollees beginning with the 2009 FFS tabulation.

Comment: One commenter inquired about what specific Cost Plan beneficiary information was included or excluded the 2000-2008 FFS data CMS released in prior years.

Response: Enrollees in Cost Plans were excluded from the enrollment tabulations but claims that were paid on fee-for-service basis for Cost Plan enrollees were included in the FFS tabulations through 2008.

Section D. IME Phase Out

Comment: One commenter said that the way the language reads in the Advance Notice, it appears that we are adjusting the specified amount by the IME phase-out amount and also making another IME phase-out adjustment to the ratebook rates (which are the blended rates). The commenter said that it appears that CMS is double counting this adjustment.

Response: The statute requires CMS to take into account the IME phase-out amount when computing the applicable amount and the specified amount of the new blended benchmark rate. Since the IME phase-out is reflected in both components, the blended rate excludes the IME phase-out appropriately.

Section E. Adjustment to FFS Per Capita Costs for VA-DoD Costs

Comment: A number of commenters offered support for the proposal to implement the VA-DoD adjustment, but requested that CMS publish a list of counties that will be impacted.

Response: We appreciate the support for implementing this adjustment. The county level VA-DoD adjustments can be found in the risk2012.csv file in the rate calculation data files posted on the CMS website.

Section F. Clinical Trials

Comment: Some commenters said that payment for clinical trials for MA plan enrollees through original Medicare creates a barrier to participation by such enrollees because it creates uncertainty as to who will pay for cost sharing. The commenters said that where enrollees face uncertainty with respect to financial obligation for cost sharing, they are less likely to participate in clinical trials.

Response: As we discussed in the 2011 Advance Notice, MA organizations are responsible for reducing cost sharing for clinical trials to the amount that their MA plan members would have for similar services provided by in-network providers. In effect, MA plan enrollees no longer have uncertainty as to the amount of cost sharing they will pay for clinical trials since it will be no different than the cost sharing they have when accessing in-network services of a similar kind.

Comment: Some commenters said that the administrative burden on members of having original Medicare pay clinical trial claims for MA plan enrollees, and then having such enrollees submit clinical trial cost sharing claims to MA organizations, is too great. The commenters said that this burden often discourages such enrollees from participating in clinical trials.

Response: Clinical trial sponsors/providers are permitted to submit original Medicare "paid" clinical trial claims to MA organizations on behalf of MA plan enrollees in order to obtain reimbursement for the difference between original Medicare cost sharing liabilities and in-

network MA plan cost sharing liabilities. Such sponsors/providers need only collect cost sharing from such enrollees once both original Medicare and MA organizations have paid.

Comment: Some commenters said that CMS should require MA organizations to cover all routine patient care costs associated with clinical trial enrollment.

Response: CMS requires MA organizations, in accordance with 42 CFR §422.109(c)(2), to provide coverage for: 1) services to diagnose conditions covered by clinical trial services, 2) most services furnished as follow-up care to clinical trial services, and; 3) services already covered by the MA organization. In requiring MA organizations to provide in-network cost sharing for clinical trial services, CMS is requiring that MA plan members have coverage for clinical trial services that is consistent with coverage they have for all other services.

Comment: Some commenters recommended that CMS adjust MA capitation rates to take into account participation by MA plan members in clinical trials. They said that CMS should have sufficient data to make such an adjustment after a decade of experience of having original Medicare pay for clinical trial services for MA enrollees. Commenters implied that this would somehow reduce the confusion surrounding cost sharing for beneficiaries.

Response: Although it is true that Medicare has nearly a decade of experience in paying for clinical trials for MA enrollees, the experience is nevertheless insufficient to make statistically valid adjustments to MA capitation rates. Also note that even if CMS were to adjust CMS capitation rates, MA organizations would still be permitted to impose cost sharing for clinical trial services similar to the cost sharing they impose on other MA plan-covered services.

Comment: Some commenters said that the Medicare coverage policy on clinical trials has removed the cost-sharing barrier for all Medicare beneficiaries with the exception of MA plan enrollees.

Response: While it may be true that original Medicare beneficiaries with Medigap or Medicare supplemental coverage with first dollar coverage do not pay any cost sharing when accessing Medicare-covered clinical trial services, it is also the case that such beneficiaries do not face cost sharing when accessing any Medicare-covered service. To the same extent that original Medicare beneficiaries without Medigap or supplemental coverage and MA plan enrollees generally do have cost sharing when accessing covered services, other than preventive services, cost sharing liabilities for clinical trial services are consistent and do not create a barrier to participation.

Comment: One commenter suggested referencing both Chapter 4 of the Medicare Managed Care Manual and the 2011 Payment Notice/Call Letter as a means of providing background on the fact that MA organizations are required to continue paying the difference between original Medicare cost sharing and in-network cost sharing when MA plan members access clinical trial services.

Response: As indicated above, the policy of requiring MA organizations to pay the difference between original Medicare cost sharing and in-network cost sharing for clinical trial services is unchanged from 2011. Also see section 10.13 – Clinical Trials – of updated Chapter 4 – Benefits and Beneficiary Protections – of the Medicare Managed Care Manual which was issued for comment by HPMS memorandum dated February 10, 2011.

Section G. ESRD Payments

G1. ESRD State Rates

Comment: A commenter questioned the methodology used to determine the ESRD state rates and has requested clarification.

Response: The 2012 ESRD state rates are based on 2006 – 2009 Medicare fee-for-service spending by beneficiaries in dialysis status. Consistent with the calibration of the ESRD risk adjustment model, the spending and enrollment is limited to beneficiaries with Medicare as primary and who have coverage for Medicare Parts A and B.

Comment: A commenter inquired about the lack of a 2% minimum update to the ESRD rates, and is requesting clarification as to how the 2% will be calculated for final 2012 ESRD rates.

Response: One intent of the Affordable Care Act was to more closely align MA payment rates with fee-for-service costs. In keeping with this intent, the ESRD state rates will be based on fee-for-service costs.

G2. Functioning Graft

Comment: One commenter expressed concern over this statement in the Advance Notice: "For 2012, CMS will pay Functioning Graft enrollees based on the blended benchmark for the county minus the amount of any rebate dollars (if any) allocated to reduce plan enrollees' Part B premium and/or Part D basic premium where the blended benchmark depends on the quality bonus payment (QBP) for the contract within which the person is enrolled." The commenter was concerned it would have different premiums for functioning graft enrollees in the plan.

Response: We are continuing our policy to pay functioning graft enrollees based on the county rate and the beneficiary's risk score; however, we are clarifying that the county rate(s) used for 2012 payment will include the changes to the benchmarks by the Affordable Care Act as well as the quality bonus payment (QBP) structure. In the Advance Notice we said, as with CMS' current functioning graft payment rules, the amount by which the plan reduces enrollees' Part B premium is a foregone revenue that remains in the Treasury, allowing CMS and SSA to decrease the enrollee's Part B premium by this amount. The amount by which the plan reduces the basic Part D premium is reflected in CMS' Part D payment to the plan.

Section H. Employer Group Waiver Plan Bidding

Comment: In the Advance Notice we announced our concerns about the level of EGWP bids relative to individual market bids and invited comments on ways to address our concerns. We have provided a summary of these comments below:

One commenter recommended one of three approaches with respect to Part C bidding for EGWPs: 1) Redesign our BPT so that where only a basic original Medicare benefit design is offered, then only administrative expenses for original Medicare benefits can be included; 2) Eliminate EGWP bids and use the average bid/rebate for each county, or; 3) Make an MAO's EGWP bid in a county equal to that MAO's bid in that county for non-EGWPs – in counties where both EGWP and non-EGWPs are offered by that MAO.

Another commenter said that EGWP bids differed from non-EGWP bids because EGWP enrollees often reside in more wide-spread geographic areas than do non-EGWP enrollees, creating higher utilization in EGWPs due to plan type (HMO for non-EGWP vs. PPO for EGWP), and other factors. This commenter recommended that CMS comprehensively study EGWP bidding before proposing policy changes.

A third commenter said that two factors lead to higher EGWP bids. The first factor, the commenter said, is that EGWPs offer "richer" benefits in the form of first dollar coverage and therefore cost sharing does not disincentivize enrollees from receiving medical services that are of marginal benefit. The second factor, the commenter said, is that enrollees with higher expected utilization are more likely to seek continued enrollment in EGWPs than are individuals with lower expected utilization.

A fourth commenter said that higher EGWP bids might be due to lower market force such plans can exert on providers due to the greater geographic dispersion of enrollees, less effective medical management programs, and the greater proportion of utilization of out-of-network providers.

One commenter cited first dollar coverage as the primary reason for higher EGWP bids.

Another commenter said that higher EGWP bids were due, primarily, to adverse enrollee selection and an imprecise risk-adjustment methodology. This commenter suggested that CMS provide its methodology for deriving the data displayed on page 20 in the "EGWP vs. Non-EGWP" bidding table. Finally, one commenter cited induced utilization due to "richer" benefits as the primary reason for higher EGWP bids.

Response: We thank all commenters for their thoughts on this issue. We will consider them as we continue to develop our EGWP bidding policy for the 2013 MA plan year.

Section I. CMS-HCC Risk Adjustment Model

Comment: A few commenters suggested that the new enrollee factor for C-SNPs should apply to all existing Medicare beneficiaries who are newly enrolling in a C-SNP instead of being applied only to those who are new to Medicare, while one commenter requested that a new enrollee factor be calculated for beneficiaries new to D-SNP plans as well.

Response: Current law requires the implementation of the new enrollee model for C-SNPs to apply only to new Medicare beneficiaries. CMS is not planning to develop a set of risk scores for continuing Medicare enrollees who are new to C-SNPs. Risk scores reflect prior year diagnoses, and given the strict rules about documenting reported diagnoses, CMS does not consider it appropriate that we impute prior year diagnoses. Many beneficiaries who are enrolled in MA plans develop conditions in the payment year that they did not have previously, and the risk model is designed to accurately predict risk across subgroups of beneficiaries, including groups of high-risk beneficiaries. As documented in our evaluation, the current model works well within subgroups of risk, including high-risk groups. As we further document, it is not clear that C-SNP enrollees are necessarily higher risk or more sick than similar FFS enrollees.

CMS is not considering applying similar new enrollee risk scores to Dual or Institutional SNP enrollees. We believe that absent explicit statutory authority we cannot pay Dual or Institutional SNPs differently from regular MA plans. Further, we are not considering applying differential new enrollee risk scores to all SNP enrollees. We believe that for Dual-eligible and Institutional SNPs' our evidence shows that the new enrollee risk scores in the CMS-HCC model are adequate to address the aggregate risk faced by these plans because the current new enrollee risk score model captures the additional costs due to Medicaid, disabled and institutional status. As discussed in previous Announcements, in creating the C-SNP model, CMS found that the increment to the new enrollee risk scores for C-SNPs is a result of chronic disease. This research also found that the increment was the same for each category (non-Medicaid, Medicaid, originally disabled) across all age/sex groups, indicating that there no further increments are needed for the costs predicted by Medicaid, original entitlement, or institutional status. These findings indicate that the predicted costs of Medicaid enrollees, originally disabled, and institutionalized enrollees are fully accounted for in the current new enrollee model.

Comment: One commenter expressed their support for CMS's decision not to implement a new Risk Adjustment Model, stating that doing so maintains stability and improved predictability in the risk adjustment methodology and MA payment rates while material revisions to the MA payment model are being implemented.

Response: We appreciate the support.

Comment: A few commenters expressed concern regarding CMS's decision to delay implementation of the version of the CMS-HCC model initially proposed in the 2011 Advance Notice, opining that CMS's decision to retain the current CMS-HCC model will significantly,

negatively and disproportionally impact Medicare payments to PACE organizations, especially in light of the fact that a large portion of PACE enrollees are diagnosed with dementia. These commenters also set forth their belief that the decision to delay implementation of the clinically revised HCC model disadvantages PACE provider organizations and PACE beneficiaries relative to most Medicare Advantage plans as a result of the differences in the populations enrolled in PACE and MA. A few commenters also recommended that CMS implement the proposed model for 2012.

Response: We appreciate these commenters support for implementing the clinically updated model. In light of the comments CMS received in this regard, CMS has reconsidered its decision to not implement the new model entirely, and noted above, and has decided to implement this model for PACE organizations in 2012.

Comment: Several commenters expressed their confusion regarding CMS's decision not to implement the updated version of the CMS-HCC model initially proposed in the 2011 Advance Notice, stating that the new model would provide significant improvement to risk adjustment, especially in light of the fact that it would have included diagnoses related to dementia for the first time. These commenters also recommended that an explanation be provided for not doing so, and for CMS to reconsider this decision for 2013.

Response: We appreciate the commenters' input and will take these comments into consideration when preparing the 2013 Advance Notice. We reiterate that our decision to implement the new model for PACE organizations only in 2012 was to provide some continuity in payment methodology for MA organizations in 2012, given other changes that are taking place.

Comment: One commenter expressed a concern that CMS has not improved risk adjustment for 2012, stating that even if CMS had implemented the new risk adjustment model as proposed in 2011 for 2012, it would not have provided meaningful improvement, and requested that CMS make additional improvements for 2012 and future years in order to decrease plan cherry-picking of healthier beneficiaries, improve the plans' incentive to focus on costs, reduce unnecessary costs and stop overpaying for low risk beneficiaries and underpaying for high risk beneficiaries.

Response: We direct the commenter to the evaluation that we are publishing at http://www.cms.gov/MedicareAdvtgSpecRateStats/06_Risk_adjustment.asp#TopOfPage, as it more thoroughly explains the risk adjustment model's performance, clears up many misconceptions about the model's ability to accurately predict costs for MA beneficiaries, and more thoroughly discusses the positive and noteworthy impact of the model changes initially proposed in 2011.

Comment: One commenter inquired as to whether CMS has reviewed those diagnoses currently excluded from the current risk adjustment model to see if including more diagnoses in the model would result in greater accuracy in risk scores for beneficiaries in SNPs as these plans were developed to serve individuals that have more specialized needs.

Response: Our model development process involves thorough assessment of the ability of each HCC to predict Medicare costs. We direct the commenter to the evaluation that we are publishing herewith at http://www.cms.gov/MedicareAdvtgSpecRateStats/06_Risk_adjustment.asp#TopOfPage, as it more thoroughly explains the processes through which the model is created, including the methodologies used to ascertain which HCC's are included within the model. In addition, the evaluation addresses model performance for C-SNPs. Please refer to the following publications for information on model development and performance: http://www.cms.gov/HealthCareFinancingReview/Downloads/04summerpg119.pdf

Section J. Recalibration of the ESRD Risk Adjustment Model

Comment: A commenter asked if the Part C and ESRD models are following different HCC models this year.

Response: The ESRD model has a different set of HCCs than the age/disabled CMS-HCC model for Payment Year 2012. The 2012 ESRD HCC model incorporates both a data recalibration and clinical update.

Comment: A commenter asked CMS to share the regression output and summary statistics from the current model and from the recalibrated model.

Response: We appreciate the support. In order to derive the model output (dollar coefficients) from the regression model, multiply the factors by the denominator. Several articles have presented information on model performance, such as R^2. Please see Pope, G.C. et.al. *Risk Adjustment of Medicare Capitation Payments Using the CMS-HCC Model*. Health Care Financing Review 25(4): 119-141, Summer 2004 at http://www.cms.gov/HealthCareFinancingReview/Downloads/04summerpg119.pdf. Robst, J, Levy, J.M., Ingber, M.J. *Diagnosis-Based Risk Adjustment for Medicare Prescription Drug Plan Payments.* Health Care Financing Review 28(4): 15-30, Summer 2007 at http://www.cms.gov/HealthCareFinancingReview/downloads/07Summerpg15.pdf.

Comment: One commenter requested more information on how the ESRD model was developed.

Response: CMS recalibrated the ESRD risk adjustment model using data from FFS claims, specifically, 2006 diagnoses were used to predict 2007 expenditures. In addition to using more recent data years in recalibrating the model, CMS also undertook a clinical update that involved reviewing the assignment of all ICD-9 diagnoses codes to diagnosis groupings that are used as the building blocks of the condition categories (CC). In consultation with a panel of outside clinicians, CMS reviewed the ICD-9 codes grouped with other clinically similar ICD-9 codes. These diagnosis groupings were then mapped to condition categories based on similar clinical

characteristics and severity, and cost implications. Both the panel of clinicians and analyses of cost data informed the creation of condition categories.

Coefficients for condition categories were estimated by regressing the total expenditure for A/B benefits for each FFS ESRD beneficiary onto their demographic factors and condition categories, as indicated by their diagnoses. Resulting dollar coefficients represent the marginal (additional) cost of the condition or demographic factor (e.g., age/sex group, Medicaid status, disability status). The inclusion of condition categories is based on each category's ability to predict costs for Medicare Parts A and B benefits. Condition categories that don't predict costs well –because the coefficient is small, the t-value is low, the number of beneficiaries with a certain condition is small so the coefficient is unstable, or the condition doesn't have well specified diagnostic coding – are not included in the model. Further, the ESRD model excludes HCCs and interaction terms for kidney-related conditions.

In a final step, hierarchies were imposed on the condition categories, assuring that more advanced and costly forms of a condition are reflected in a higher coefficient.

Please note that, since there are new ICD-9 codes that map to HCCs in the revised ESRD model for 2012, these new ICD-9 codes should be submitted for dates of services in 2011.

Section K. Adjustment for MA Coding Pattern Differences

Comment: Several commenters supported CMS's decision to maintain the level of the 2011 adjustment for 2012, stating that doing so maintains stability and improved predictability in the risk adjustment methodology and MA payment rates while material revisions to the MA payment model are being implemented.

Response: We appreciate the support for maintaining the current coding pattern adjustment.

Comment: One commenter stated that the adjustment should not be applied to the "Specified" portion of the rates as this amount is a percent of FFS costs, and questions why the adjustment is applied to the risk scores.

Response: The DRA requires the Secretary, in risk adjusting payments to plans, to reflect an adjustment for differences in *coding patterns* between Medicare Advantage plans and FFS providers under Part A and B, to the extent that the Secretary has identified such differences. The reason for applying this adjustment to beneficiaries' risk scores is because these coding pattern differences influence the risk scores of beneficiaries enrolled in MA plans, and not the rates.

Comment: One commenter asked how CMS will take into account the RADV audits in developing the coding intensity adjustment for 2012 and future years.

Response: As we have noted in previous Advance Notices and Rate Announcements, the MA coding adjustment factor is not intended to adjust for inaccurate coding, but for the impact on

risk scores of coding patterns that differ from FFS coding, the basis of the CMS-HCC model and the Part C normalization factor. RADV audits, on the other hand, have the purpose of validating that diagnosis codes submitted for risk adjustment are documented in the medical record and, therefore, are correctly reported for the beneficiary in question.

Comment: One commenter expressed confusion about the amount of the adjustment and requested an explanation of the methodology used to create adjuster being applied in 2012.

Response: The methodology for creating the 3.41% coding adjustment being applied in 2012 is described in detail in the 2010 Final Rate Announcement which can be found at: http://www.cms.gov/MedicareAdvtgSpecRateStats/Downloads/Announcement2010.pdf

Section L. Frailty Adjustment

Comment: Several commenters asked that CMS pay frailty at an individual level. These commenters asked that CMS pay this frailty adjuster to the nursing home certifiable population enrolled in the plan. Some of these commenters also asked that CMS only survey those enrollees who are nursing home certifiable. Another commenter asked that CMS apply frailty for beneficiaries who qualify for the home and community based program within a state.

Response: Because ADL data are collected via survey for a subset of a plan's membership, it is not possible to pay frailty calculated at an individual level for all enrollees in a plan. In addition, because the survey is developed based on a random sample of enrollees, allowing plans to select enrollees to be surveyed would violate the principle of randomization, which would mean that the frailty score could not be generalized to the entire plan. The frailty model is calibrated using a similar methodology of a randomized sample across the FFS population. Therefore, frailty factors reflect the proper weights for this survey approach to measuring frailty in a population. As to the home and community based program, we believe that the differences in eligibility criteria by state for these programs could make comparison between FIDE SNPs difficult.

Comment: Several commenters asked that CMS pay frailty to the under 55 population that has frailty similar to PACE.

Response: When we developed the frailty model, we determined that it did not help predict unexplained costs of beneficiaries under age 55.

Comment: Several commenters asked CMS to consider collecting data from state level assessments of frailty. One commenter stated that a plan should qualify for frailty if a member has been accepted into a SNP by virtue of a State approved assessment tool.

Response: CMS will continue to evaluate alternative sources of data, including state level assessments, to determine frailty. We believe, however, that the HOS survey, because it can be sampled at the PBP level, provides our best estimate of a plan's frailty score. In addition, the

survey is standardized, unlike the state level assessments, which can vary from one state to the next.

Comment: One commenter noted that the intent of the Affordable Care Act provision was to pay frailty to the integrated dual eligible programs that had previously existed outside of PACE before 2004.

Response: The statute directs CMS to look at a plan's level of frailty in comparison to PACE. We believe that our policy is consistent with the statute.

Comment: Several commenters asked CMS to consider using alternative measures of frailty, noting that researchers have identified five core frailty measures in "Untangling the Concepts of Frailty, Disability and Comorbidities," including generalized weakness, poor endurance, weight loss and/or undernourishment, low activity (including being homebound), and fear of falling and/or unsteady gait."[1] These commenters also noted that "there is a growing consensus in the geriatric community that frailty, disability and comorbidity are "'distinct clinical entities that are causally related.'"

Response: CMS recognizes that frailty has many aspects, including the five core frailty measures mentioned by the commenters. However, we disagree that there is, in fact, a consensus about how to define frailty. A recent study notes the following:

> "No clear consensual definition regarding frailty seems to emerge from the literature after 30 years of research in the topic, and a large array of models and criteria has been proposed to define the syndrome. Controversy continues to exist on the choice of the components to be included in the frailty definition. Two main definitions based on clusters of components are found in literature: a physical phenotype of frailty, operationalized in 2001 by providing a list of 5 measurable items of functional impairments, which coexists with a multidomain phenotype, based on a frailty index constructed on the accumulation of identified deficits based on comprehensive geriatric assessment. The physical phenotype considers disability and comorbidities such as dementia as distinct entities and therefore outcomes of the frailty syndrome, whereas comorbidity and disability can be components of the multidomain phenotype. Expanded models of physical frailty (models that included clusters other than the original 5 items such as dementia) increased considerably the predicting capacity of poor clinical outcomes when compared with the predictive capacity of the physical phenotype"[2]

CMS will continue to conduct research into ways to refine our frailty methodology. We have concerns about the feasibility of collecting detailed data on the five aspects of frailty without causing undue burden on plans. Given this potential burden, and consistent with studies we have conducted on this topic, we believe that ADLs provide an adequate measure of frailty that can be obtained based on available survey data.

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[1]Fried, L et. al., Untangling the Concepts of Disability, Frailty, and Comorbidity: Implications for Improving Targeting and Care", Journal of Gerontology, Medical Sciences, 2004, Vol. 59, No. 3, 255-263.

[2]Abellan van Kan G, Rolland Y, Houles M, Gillette-Guyonnet S, Soto M, Vellas B.The assessment of frailty in older adults. Clin Geriatr Med. 2010 May;26(2):275-86.

Comment: One commenter stated that CMS should identify frailty individuals based on those who qualify for $0 cost sharing based on the Part D Best Available Evidence policy.

Response: CMS does not believe that $0 cost sharing would indicate frailty, and we would not be able to distinguish frailty levels for these individuals without survey data.

Comment:
CMS received 14 comments on the application of frailty adjusted payments to FIDE SNPs. The comments expressed a range of views including support for applying frailty adjustment to any FIDE SNPs within the PACE range to not applying frailty to FIDE SNPs unless the frailty adjustment was available across the entire MA program. Some commenters also noted that certain states require Medicaid managed care plans to accept all enrollees, so enrollees will be less frail than PACE enrollees. According to these commenters, not using the range of frailty scores will result in FIDE SNPs separating their pans into nursing home certifiable and non-nursing home certifiable populations.

Response: We agree with the commenters that recommend using the minimum score of the PACE range of frailty scores to determine whether FIDE SNPs have frailty similar to PACE for the purpose of implementing this provision of the ACA.

In order to compare FIDE SNP frailty scores to PACE frailty scores for 2012, we will first establish a PACE organization range of frailty based upon those PACE organizations with at least 100 respondents to the 2011 HOS survey. Once the PACE range is established, those FIDE SNPs that have a frailty score above the minimum PACE score will receive a frailty add-on to their beneficiaries risk scores. Low enrollment (30 or fewer respondents to the HOS/HOS-M) or new FIDE SNPs (those who were not eligible to participate in the 2011 HOS because they were not eligible due to the length of time the plan was in operation) will receive a frailty score equal to the 2012 average FIDE SNP frailty score as determined by the data received from 2011 HOS survey. For comparison purposes, both the PACE range of frailty and the FIDE SNP frailty scores will be based upon the frailty factors used to calculate the frailty scores for payment to the FIDE SNP plans as published in this Notice.

Section M. Normalization Factors

Comment: Many commenters requested a more detailed explanation of the methodology and calculations used to determine the normalization factors. These commenters also expressed concern about the increase in the normalization for 2012 being significantly higher than historical changes. A few commenters also inquired if CMS is accounting for the influx of the baby boomer population into Medicare when deriving this factor.

Response: The formula for calculating normalization factors used to adjust risk scores takes into account the following factors:

(1) The annual trend, calculated over a rolling set of annual risk scores. (2) The number of years between the denominator year and the payment year.

In the case of both the Part C and Part D, each year's normalization factor may change marginally due to updating the annual trend and, to a larger degree, as a result of any change in the gap between the denominator year and the payment year. The change in the normalization factor to account for coding trends between the denominator year and the payment year should not affect a plan's risk score, as long as the plan's coding trend is consistent with the average trend.

When we project the normalization factor for the payment year, we use the most recent fee-for-service data available. For 2012 the most recent year is 2010, which we believe is current enough to reflect recent trends. We have decided to calculate an annual trend over as many as five years of risk scores specifically to smooth this trend.

Normalization Factor for the CMS-HCC Model
The final 2012 CMS-HCC Part C model normalization factor is 1.079.

- The Part C normalization factor is used to normalize the following risk scores: Aged/disabled community, aged/disabled institutional and aged/disabled new enrollee.
- Population used to calculate annual trend: FFS beneficiaries.

CMS estimates an annual trend using a linear function applied to the following years' risk scores:

2006: 0.984
2007: 1.000
2008: 1.009
2009: 1.031
2010: 1.046

The linear annual trend over these five years (2006-2010) is 0.0154. This annual trend is applied for the years between the denominator year (2007) and the payment year (2012) by taking it to the fifth power. The normalization factor is obtained as follows: $1.0154^5 = 1.079$.

Section N. ACA Evaluation

Comment: Several commenters expressed the belief that it was Congress's intent for this evaluation to be included in the Advance Notice so that plans would have an opportunity to comment. Several of these commenters are requesting that CMS publish the evaluation prior to the Announcement thereby giving plans time to submit comments, while others are requesting for a comment period after it is published in the Rate Announcement. A few plans stated that they believe Congress intended for CMS to implement changes to risk adjustment as a result of

the evaluation and do not believe that CMS has not improved risk adjustment for 2012. One commenter encouraged CMS to undertake a comprehensive survey of all SNPs to inform the risk adjustment methodology regarding frailty and comorbitities.

Response: The statute at 1853(a)(1)(C)(iii)(IV) of the Act states that the Secretary shall publish the evaluation as part of the "announcement under subsection (b)." We interpret this to mean that the evaluation should be published in the Announcement of Calendar Year (CY) 2012 Medicare Advantage Capitation Rates and Medicare Advantage and Part D Payment Policies and Final Call Letter. As also provided in statute, we will evaluate the risk adjustment system in order to assess its ability to account for higher medical and care coordination costs associated with frailty, individuals with multiple, comorbid chronic conditions, and individuals with a diagnosis of mental illness, and also to account for costs that may be associated with higher concentrations of beneficiaries with those conditions. The risk adjustment evaluation can be found on the CMS website at http://www.cms.gov/MedicareAdvtgSpecRateStats/06_Risk_adjustment.asp#TopOfPage.

Comment: One commenter requested that CMS recognize problems in the 10 decile analysis for high risk chronically ill beneficiaries stating that the model inappropriately treats high spending chronically ill beneficiaries as healthy causing them to be assigned to a lower than "true" risk decile.

Response: We measure model predictive strength by comparing predicted costs to actual

costs. We typically group beneficiaries into risk deciles, meaning that we create ten equal-sized groups of beneficiaries, ranging from the group with the highest predicted costs to the group with the lowest predicted costs. For each risk-based group, we then create ratios of predicted costs to actual costs. Using predictive ratios, we find that the CMS-HCC model performs well. Comparing predictive ratios across beneficiaries grouped by actual costs (as the comment implies) is not an actuarially sound way to look at the ability of the model to accurately predict costs. If one looks at the cost data retrospectively (after the fact) the result will always be that high cost beneficiaries are under-predicted as high cost is largely due to random events. Determining whether the costs associated with beneficiaries predicted to be high, medium or low cost is the only actuarially sound way to evaluate the risk adjustment model.

Section O. Encounter Data Collection

Comment: At least three plans commented on the burden brought about by changing the submission guidelines for Encounter Data. Some confusion also exists on how frequently plans have to submit data and what the deadlines are around these submissions.

Response: CMS is in the process of creating an encounter data managed care manual discussing issues related to these comments. We plan to release the manual early this summer.

Comment: One commenter asked CMS to clarify its statement that it intends to reimburse Medicare Cost plans for the cost of gathering and submitting encounter data. They asked us to clarify whether we would pay for creation of data systems that could be used for other purposes.

Response: Consistent with our long-standing policy, we will not reimburse full cost for the creation or enhancement of data systems that can be used for other purposes. Reasonable costs for such system's development or enhancement may, however, be claimed (where appropriate) under normal administrative and general cost reimbursement rules found in §417.564.

Comment: Some MAO plans commented that CMS should consider delaying the deployment of the new ED requirements due to the significant increase in resources needed for ED and ICD-10 within a short timeframe.

Response: CMS appreciates that the system implementation timeline for encounter data and ICD-10 may place additional burden on some of the Medicare Advantage Organizations (MAO) and Third Party Administrators (TPA). The Plans were informed of the implementation of Encounter Data through the 2011 Advanced Notice published February 2010, technical requirements were provided in the April 2010 Rate Announcement, and additional information regarding the implementation schedule and requirements were discussed during the National Encounter Data meeting held on October 29, 2010. Given the amount of notice and the extensive industry consultation, CMS does not propose to delay implementation of encounter data requirements.

Comment: Some MA plans commented on what CMS intends to do with the data it receives through the new ED requirements.

Response: We intend to use the data in accordance with our regulation at 42 CFR 422.310(f), which states CMS uses the data to determine the risk adjustment factors used to adjust payments, … for updating risk adjustment models, calculating Medicare DSH percentages, conducting quality review and improvement activities, and for Medicare coverage purposes.

Section P. Risk Adjustment Processing System (RAPS) File Changes

Comment: One commenter asked why CMS is planning to make new changes to the RAPS file format for use in 10/2013. The commenter asked CMS to clarify whether 2013 RAPS or encounter data will be used to calculate payments. The commenter asked for more detail regarding the proposed change and timing.

Response: CMS is planning to make changes to the RAPS file format to accommodate ICD 10 codes starting in 2013. We plan to run both the RAPS and encounter systems until the encounter data is complete and accurate enough to support risk adjustment payment and model development.

Section Q. Risk Adjustment Data Validation (RADV)

Comment: Several commenters objected to CMS's plans to continue contract-level Risk Adjustment Data Validation (RADV) audits in 2012 and recommend that CMS hold-off conducting further contract-specific RADV audits until the Agency addresses questions already submitted to CMS.

Response: On Tuesday, December 21, 2010, CMS posted a description of the Agency's proposed draft RADV sampling and payment error calculation methodology on our website at http://www.cms.gov/HealthPlansGenInfo/ and invited public comment on this document. To date, we have received comments on a variety of RADV topics. We are thoroughly evaluating all comments and anticipate making changes to our draft, based on input we received. We anticipate the final revised RADV sampling and payment error calculation methodology paper will be issued in the near future. CMS also plans to issue a question and answer document that summarizes the comments received on the RADV methodology and the Agency's response to those comments.

Section R. Prospective Coverage Gap Discount Program (CGDP) Payments

Comment: One commenter asked CMS to clarify our use of the term "fill fees" in this section of the Advance Notice.

Response: In this section of the Advance Notice, "fill fees" refers to dispensing fees and vaccine administration fees, both of which are excluded from the manufacturer discounts provided under the CGDP.

Comment: In the Advance Notice, we requested public comment regarding the prospective CGDP payments for fill fees. The calculation methodology proposed in the Advance Notice did not apply a downward adjustment to the prospective CGDP payments to reflect that manufacturer discounts under the CGDP do not include fill fees. A few commenters recommended that CMS apply an adjustment to the prospective CGDP payments for fill fees. They indicated that applying such an adjustment would improve the accuracy of the prospective payments since manufacturer discounts under the CGDP do not include fill fees. Two commenters agreed with our proposed methodology and indicated that no adjustment should be applied because fill fees vary significantly and will have a minimal impact on the prospective CGDP payments. One commenter expressed a concern that excluding fill fees from the prospective CGDP payments would be a change from 2011. The commenter asserted such a change would create significant administrative burden due to changes to Part D sponsors' accounting and IT systems. Overall, commenters asked that CMS make any adjustments for fill fees as simple as possible.

Response: We do not believe that it is necessary to adjust the prospective CGDP payments for fill fees. We agree with commenters that fill fees are small relative to manufacturer discounts

under the CGDP and therefore will have little impact on the prospective CGDP payments. Consistent with the guidance in the May 21, 2010 HPMS memo, "Medicare Coverage Gap Discount Program Beginning in 2011: Revised Part D Sponsor Guidance and Responses to Summary Public Comments on the Draft Guidance", any prospective CGDP payments that exceed the manufacturer discounts made available under the CGDP will be recouped by CMS during the CGDP reconciliation process.

Section S. Cost Sharing for Applicable Beneficiaries in the Coverage Gap

Comment: One commenter requested clarification regarding whether Part D sponsors should assume that in general, generic drugs are non-applicable and brand drugs are applicable when developing their Part D bids.

Response: While in general applicable drugs are brand drugs and non-applicable drugs are generic drugs, Part D sponsors should not use this assumption when developing their Part D bids. There are cases where a brand drug may be considered a non-applicable drug and a generic drug may be considered an applicable drug. Therefore, the Part D bids should be developed consistent with the definition of applicable drug in Section 1860D-14A(g)(2) of the Social Security Act and the Instructions for Completing the Prescription Drug Plan Bid Pricing Tool for Contract Year 2012.

Comment: One commenter expressed concern that the term "manufacturer discounts" could be confused with discounts unrelated to the CGDP. The commenter recommended use of the term "manufacturer coverage gap discount" to provide greater clarity for Part D sponsors when implementing the CGDP.

Response: CMS appreciates this comment and will consider the use of this term in future guidance regarding the CGDP.

Section T. Update of the Rx-HCC Model

Comment: One commenter inquired as to whether or not CMS will recalibrate the RxHCC model every year in light of the changes in the percentage of generic coverage for non-LIS beneficiaries.

Response: CMS anticipates a need to recalibrate the RxHCC model on a regular basis to factor in the impact of the new Medicare Part D benefit structure. The Advance Notice will announce the details of any future changes, such as recalibrations, to the RxHCC model.

Comment: One commenter appreciates and concurs with CMS' update of the RxHCC model. In addition, the commenter requests that greater transparency be shown via providing the details used in recalibration of the model – specifically, regression model output and summary statistics from the current and recalibrated RxHCC models to show improved payment accuracy.

Response: We appreciate the support. In order to derive the model output (dollar coefficients) from the regression model, multiply the factors by the denominator. Several articles have presented information on model performance, such as R^2. Please see Pope, G.C. et.al. *Risk Adjustment of Medicare Capitation Payments Using the CMS-HCC Model*. Health Care Financing Review 25(4): 119-141, Summer 2004 at http://www.cms.gov/HealthCareFinancingReview/Downloads/04summerpg119.pdf. Robst, J, Levy, J.M., Ingber, M.J. *Diagnosis-Based Risk Adjustment for Medicare Prescription Drug Plan Payments.* Health Care Financing Review 28(4): 15-30, Summer 2007 at http://www.cms.gov/HealthCareFinancingReview/downloads/07Summerpg15.pdf.

Section U. De Minimis Premium Policy

Comment: One commenter supported CMS' approach in regards to the *de minimis* premium policy and requested greater freedom for plans that target the low income premium subsidy level in their bid to make premium concessions.

Response: CMS appreciates the support. The *de minimis* amount is determined yearly based on the outcome of the plan bidding process. The impacts of setting the *de minimis* amounts at varying levels are considered each year, including the ability for plans to meet the low income premium target and offer a zero premium plan to LIS beneficiaries. We also consider the number of reassignments resulting from varying *de minimis* levels. CMS will continue this approach of analyzing plan bids and determining impacts prior to announcing the *de minimis* amount in August.

Section V. Payment Reconciliation

Comment: In general, commenters supported the risk corridors proposed for 2012. One Part D sponsor indicated that the continuation of the risk corridors is important because the sponsor experiences significant variations in risk sharing each year. Commenters asked that we continue to review our risk sharing data and make appropriate adjustments to the risk percentages to reduce payments recouped from Part D sponsors and better align risk sharing with the cost containment efforts of Part D sponsors. One commenter indicated that widening the risk corridors will discourage irrational pricing intended to shift downside risk to CMS.

Response: We appreciate the support and will continue to review our risk sharing data each year to assess whether any changes should be made to the risk corridors.

Section W. Medicare Part D Benefit Parameters: Annual Adjustments for Defined Standard Benefit in 2012

Comment: One commenter requests that CMS display the maximum total drug costs that a member may incur at the TrOOP threshold, or alternatively, to explain how the Estimated Total Covered Part D Spending for Applicable Beneficiaries for 2012 ($6,730.39) was developed.

Response: We note that the "Estimated Total Covered Part D Spending for Applicable Beneficiaries" is more accurately called "Estimated Total Covered Part D Spending at Out-of-Pocket Threshold for Applicable Beneficiaries" and are thus modifying the term in the Part D Benefit Parameters chart. This value of $6,730.39 for 2012 is an estimate of the average amount of total drug spending for an applicable beneficiary to attain the out-of-pocket threshold in the defined standard benefit. The purpose of providing this value is to enable enhanced alternative plans to map enhanced alternative coverage to the defined standard benefit, which is necessary for purposes of calculating the covered plan paid amounts (CPP) reported on the prescription drug event (PDE) records. The value is based on PDE data showing the historical average applicable and non-applicable drug spending in the coverage gap. The calculation for Estimated Total Covered Part D Spending at Out-of-Pocket Threshold for Applicable Beneficiaries for 2012 is shown on page 43 of the Advance Notice and Rate Announcement for 2012.

Comment: One commenter requested that the Part D Benefit Parameters chart reflect $0 cost sharing for dual eligibles receiving home and community based services.

Response: Section 3309 of the Affordable Care Act extended the elimination of Part D cost sharing to full benefit dual eligibles who would be institutionalized individuals (or an institutionalized couple) if the individuals were not receiving home and community-based services (HCBS) under Title XIX of the Act. The effective date for this requirement will be no earlier than January 1, 2012. We have proposed an implementation date of January 1, 2012 in our November 15, 2010 proposed rule. Should this proposed effective date be finalized in our final rule, the Final Updated Part D Benefit Parameters for Defined Standard Benefit, Low-Income Subsidy, and Retiree Drug Subsidy will reflect zero cost sharing for these individuals. We have included a placeholder in the chart in Attachment IV in consideration of this comment.

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

Annual Percentage Increases

	Annual percentage trend for 2011	Prior year revisions	Annual percentage increase for 2011
Applied to all parameters but (1)	4.67%	-1.27%	3.34%
CPI (all items, U.S. city average): Applied to (1)	1.42%	-0.43%	0.98%

Part D Benefit Parameters

	2011	2012
Standard Benefit		
Deductible	$310	$320
Initial Coverage Limit	$2,840	$2,930
Out-of-Pocket Threshold	$4,550	$4,700
Total Covered Part D Spending at Out-of-Pocket Threshold for Non-Applicable Beneficiaries (2)	$6,447.50	$6,657.50
Estimated Total Covered Part D Spending at Out-of-Pocket Threshold for Applicable Beneficiaries (3)	$6,483.72	$6,730.39
Minimum Cost-Sharing in Catastrophic Coverage Portion of the Benefit		
Generic/Preferred Multi-Source Drug	$2.50	$2.60
Other	$6.30	$6.50
Full Subsidy-Full Benefit Dual Eligible (FBDE) Individuals		
Deductible	$0.00	$0.00
Copayments for Institutionalized Beneficiaries [category code 3]	$0.00	$0.00
Copayments for Beneficiaries Receiving Home and Community-Based Services (4) [category code 3] (if effective date is January 1, 2012 as proposed)	--	$0.00
Maximum Copayments for Non-Institutionalized Beneficiaries		
Up to or at 100% FPL [category code 2]		
Up to Out-of-Pocket Threshold (1)	$1.10	$1.10
Generic/Preferred Multi-Source Drug (5)	$3.30	$3.30
Other (5)	$0.00	$0.00
Above Out-of-Pocket Threshold		
Over 100% FPL [category code 1]		
Up to Out-of-Pocket Threshold	$2.50	$2.60
Generic/Preferred Multi-Source Drug	$6.30	$6.50
Other		
Above Out-of-Pocket Threshold	$0.00	$0.00
Full Subsidy-Non-FBDE Individuals		
Eligible for QMB/SLMB/QI, SSI or applied and income at or below 135% FPL and resources ≤ $6,680 (individuals) or ≤ $10,020 (couples) (6) [category code 1]		
Deductible	$0.00	$0.00
Maximum Copayments up to Out-of-Pocket Threshold		
Generic/Preferred Multi-Source Drug	$2.50	$2.60
Other	$6.30	$6.50
Maximum Copayments above Out-of-Pocket Threshold	$0.00	$0.00
Partial Subsidy		
Applied and income below 150% FPL and resources below $11,140 (individual) or $22,260 (couple) [category code 4]		
Deductible	$63.00	$65.00
Coinsurance up to Out-of-Pocket Threshold	15%	15%
Maximum Copayments above Out-of-Pocket Threshold		
Generic/Preferred Multi-Source Drug	$2.50	$2.60
Other	$6.30	$6.50
Retiree Drug Subsidy Amounts		
Cost Threshold	$310	$320
Cost Limit	$6,300	$6,500

(1) CPI adjustment applies to copayments for non-institutionalized beneficiaries up to or at 100% FPL.

(2) For beneficiaries who are *not* considered an "applicable beneficiary" as defined at section 1860D-14A(g)(1) and therefore are not eligible for the coverage gap discount program (i.e. LIS beneficiaries), this is the amount of total drug spending required to attain out-of-pocket threshold in the defined standard benefit if the beneficiary does not have prescription drug coverage through a group health plan, insurance, government-funded health program or

similar third party arrangement. Enhanced alternative plans must use this value when mapping enhanced alternative coverage plans to the defined standard benefit, for the purposes of calculating the covered plan paid amounts (CPP) reported on the prescription drug event (PDE) records.

(3) For beneficiaries who are considered an "applicable beneficiary" as defined at section 1860D-14A(g)(1) and therefore are eligible for the coverage gap discount program (i.e. non-LIS beneficiaries), this is the estimated average amount of total drug spending required to attain the 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. Enhanced alternative plans must use this value when mapping enhanced alternative coverage to the defined standard benefit, for purposes of calculating the covered plan paid amounts (CPP) reported on the prescription drug event (PDE) records.

(4) Per section 1860D-14(a)(1)(D)(i), full-benefit dual eligibles who would be institutionalized individuals (or couple) if the individual (or couple) was not receiving home and community-based services qualify for zero cost-sharing as of an effective date (no earlier than January 1, 2012) specified by the Secretary. We proposed an effective date of January 1, 2012, and should our proposed rule be finalized with an effective January of 1, 2012, cost sharing for this population would be zero beginning January 1, 2012. (5) The increases to the LIS deductible, generic/preferred multi-source drugs and other drugs copayments are applied to the unrounded 2011 values of $63.12, $1.10, and $3.31, respectively.

(6) The actual amount of resources allowable will be updated for contract year 2012.

Attachment V. Medicare Part D Benefit Parameters for the Defined Standard Benefit: Annual Adjustments for 2012

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 2012, 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 $310 in 2011 and rounded to the nearest multiple of $5.

Initial Coverage Limit: From $2,840 in 2011 and rounded to the nearest multiple of $10.

Out-of-Pocket Threshold: From $4,550 in 2011 and rounded to the nearest multiple of $50.

Minimum Cost-Sharing in the Catastrophic Coverage Portion of the Benefit: From $2.50 per generic or preferred drug that is a multi-source drug, and $6.30 for all other drugs in 2011, 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 $2.50 per generic or preferred drug that is a multi-source drug, and $6.30 for all other drugs in 2011, and rounded to the nearest multiple of $0.05.

Deductible for Low Income (Partial) Subsidy Eligible Enrollees: From $63[3] in 2011 and rounded to the nearest $1.

Maximum Copayments above the Out-of-Pocket Threshold for Low Income (Partial) Subsidy Eligible Enrollees: From $2.50 per generic or preferred drug that is a multi-source drug, and $6.30 for all other drugs in 2011, 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 $3.30 for all other drugs in 2011[4], 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

[3] 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 2011 value of $63.12.

[4] Consistent with the statutory requirements of 1860D-14(a)(4)(A) of the Social Security Act, the copayments are increased from the unrounded 2011 values of $1.10 per generic or preferred drug that is a multi-source drug, and $3.31 for all other drugs.

program data. For the 2012 contract year benefit parameters, Part D program data is used to calculate the annual percentage trend as follows:

$$\frac{August\,2010 - July\,2011}{August\,2009 - July\,2010} = \frac{\$2{,}924.44}{\$2{,}793.88} = 1.0467$$

In the formula, the average per capita cost for August 2009 – July 2010 ($2,793.88) is calculated from actual Part D prescription drug event (PDE) data and the average per capita cost for August 2010 – July 2011 ($2,924.44) is calculated based on actual Part D PDE data incurred from August – December, 2010 and projected through July, 2011.

The 2012 benefit parameters reflect the 2011 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 annual percentage increases are now estimated as summarized by Table III-2.

Table III-2. Revised Prior Years' Annual Percentage Increases

Year	Prior Estimates of Annual Percentage Increases	Revised Annual Percentage Increases
2007	6.48%	6.74%
2008	5.12%	5.36%
2009	4.42%	4.44%
2010	3.22%	3.07%
2011	4.63%	2.96%

Accordingly, the 2012 benefit parameters reflect a multiplicative update of -1.27% for prior year revisions. In summary, the 2011 parameters outlined in section I are updated by 3.34% for 2012 as summarized by Table III-3.

Table III-3. Annual Percentage Increase

Annual percentage trend for July 2011	4.67%
Prior year revisions	−1.27%
Annual percentage increase for 2012	3.34%

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 2012, the September 2011 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 2011 CPI based on the projected amount included in the President's FY2012 Budget. The September 2010 value is from the Bureau of Labor Statistics. The annual percentage trend in CPI for contract year 2012 is calculated as follows:

$$\frac{\text{Projected September 2011 CPI}}{\text{Actual September 2010 CPI}} \textit{ or } \frac{221.550}{218.439} = 1.0142$$

(Source: President's FY2012 Budget and Bureau of Labor Statistics, Department of Labor)

The 2012 benefit parameters reflect the 2011 annual percentage trend in the CPI, as well as a revision to the prior estimate for the 2010 annual percentage increase. The 2011 parameter update reflected an annual percentage trend in CPI of 1.58%. Based on the actual reported CPI for September 2010, the September 2010 CPI increase is now estimated to be 1.14%. Thus, the 2012 update reflects a multiplicative -0.43% correction for prior year revisions. In summary, the cost sharing items outlined in section II are updated by 0.98% for 2012 as summarized by Table III-4.

Table III-4. Cumulative Annual Percentage Increase in CPI

Annual percentage trend for September 2011	1.42%
Prior year revisions	-0.43%
Annual percentage increase for 2011	0.98%

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

Estimated Total Covered Part D Spending at Out-of-Pocket Threshold for Applicable Beneficiaries

For 2012, the Total Covered Part D Spending at OOP Threshold for Applicable Beneficiaries is $6,730.39. The Total Covered Part D Spending at OOP Threshold for Applicable Beneficiaries is calculated as the ICL plus 100% beneficiary cost sharing in the coverage gap divided by the weighted gap coinsurance factor. This value is calculated assuming 100% cost sharing in the deductible phase, 25% in the initial coverage phase, and in the coverage gap, 86% for non-applicable (generic) drugs and 100% for applicable (brand) drugs.

Total Covered Part D Spending at OOP Threshold for Applicable Beneficiaries is calculated for 2012 as follows:

$$\text{ICL} + \frac{\text{100\% beneficiary cost sharing in the gap}}{\text{weighted gap coinsurance factor}} \quad \textit{or} \quad \$2930 + \frac{\$3727.50}{98.082\%} = \$6{,}730.39$$

where 100% of the beneficiary cost sharing in the gap is the estimated total drug spending in the gap assuming 100% coinsurance.

100% beneficiary cost sharing in the gap is calculated as follows for 2012:

OOP threshold – OOP costs up to the ICL *or* $4,700 − $972.50 = $3,727.50

Weighted gap coinsurance factor is calculated for 2012 as follows:

(Brand GDCB % for non-LIS × 100% cost sharing for applicable drugs) + (Generic GDCB % for non-LIS × 86% cost sharing for non-applicable drugs) *or* (86.3% × 100%) + (13.7% × 86%) = 98.082%

where:

- Brand GDCB % for non-LIS is the percentage of gross covered drug costs below the out-of-pocket threshold for applicable beneficiaries attributable to applicable (brand) drugs as reported on the 2010 PDE records;
- Gap cost sharing for applicable drugs is the coinsurance incurred by applicable beneficiaries for applicable (brand) drugs in coverage gap;
- Generic GDCB % for non-LIS is the percentage of gross covered drug costs below the out-of-pocket threshold for applicable beneficiaries attributable to non-applicable (generic) drugs as reported on the 2010 PDE records; and
- Gap cost sharing for non-applicable drugs is the coinsurance incurred by applicable beneficiaries for non-applicable (generic) drugs in coverage gap.

IV. 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 $310 and $6,300, respectively, for plans that end in 2010, and, as $310 and $6,300, respectively, for plans that end in 2011. For 2012, the cost threshold is $320 and the cost limit is $6,500.

Attachment VI. ESRD, and Rx-HCC Risk Adjustment Factors

Tables

Table 1. ESRD Model Continuing Enrollee Dialysis Relative Factors

Variable	Relative Factors
Female	
0-34 Years	0.598
35-44 Years	0.598
45-54 Years	0.598
55-59 Years	0.606
60-64 Years	0.619
65-69 Years	0.686
70-74 Years	0.702
75-79 Years	0.717
80-84 Years	0.739
85-89 Years	0.745
90-94 Years	0.745
95 Years or Over	0.745
Male	
0-34 Years	0.589
35-44 Years	0.589
45-54 Years	0.589
55-59 Years	0.599
60-64 Years	0.609
65-69 Years	0.661
70-74 Years	0.686
75-79 Years	0.695
80-84 Years	0.736
85-89 Years	0.752
90-94 Years	0.752
95 Years or Over	0.752
Medicaid, Originally Disabled, and Originally ESRD Interactions with Age and Sex	
Medicaid_Female_Aged	0.052
Medicaid_Female_NonAged (Age <65)	0.057
Medicaid_Male_Aged	0.065
Medicaid_Male_NonAged (Age <65)	0.033
Originally Disabled_Female[2]	0.049
Originally Disabled_Male[2]	0.045
Originally ESRD_Female[3]	-0.062
Originally ESRD_Male[3]	-0.045

Disease Group	Description Label	RelativeFactors
HCC1	HIV/AIDS	0.171
HCC2	Septicemia, Sepsis, Systemic Inflammatory Response Syndrome/Shock	0.077
HCC6	Opportunistic Infections	0.080
HCC8	Metastatic Cancer and Acute Leukemia	0.251
HCC9	Lung and Other Severe Cancers	0.172
HCC10	Lymphoma and Other Cancers	0.106
HCC11	Colorectal, Bladder, and Other Cancers	0.058
HCC12	Breast, Prostate, and Other Cancers and Tumors	0.031
HCC17	Diabetes with Acute Complications	0.202
HCC18	Diabetes with Chronic Complications	0.087
HCC19	Diabetes without Complication	0.075
HCC21	Protein-Calorie Malnutrition	0.037
HCC22	Morbid Obesity	0.132
HCC23	Other Significant Endocrine and Metabolic Disorders	0.004
HCC27	End-Stage Liver Disease	0.201
HCC28	Cirrhosis of Liver	0.085
HCC29	Chronic Hepatitis	0.053
HCC33	Intestinal Obstruction/Perforation	0.057
HCC34	Chronic Pancreatitis	0.039
HCC35	Inflammatory Bowel Disease	0.056
HCC39	Bone/Joint/Muscle Infections/Necrosis	0.068
HCC40	Rheumatoid Arthritis and Inflammatory Connective Tissue Disease	0.075
HCC46	Severe Hematological Disorders	0.148
HCC47	Disorders of Immunity	0.031
HCC48	Coagulation Defects and Other Specified Hematological Disorders	0.076
HCC51	Dementia With Complications	0.127

Disease Group	Description Label	RelativeFactors
HCC52	Dementia Without Complication	0.060
HCC54	Drug/Alcohol Psychosis	-
HCC55	Drug/Alcohol Dependence	-
HCC57	Schizophrenia	0.136
HCC58	Major Depressive, Bipolar, and Paranoid Disorders	0.084
HCC70	Quadriplegia	0.206
HCC71	Paraplegia	0.206
HCC72	Spinal Cord Disorders/Injuries	0.105
HCC73	Amyotrophic Lateral Sclerosis and Other Motor Neuron Disease	-
HCC74	Cerebral Palsy	0.068
HCC75	Polyneuropathy	0.056
HCC76	Muscular Dystrophy	-
HCC77	Multiple Sclerosis	0.069
HCC78	Parkinson's and Huntington's Diseases	0.055
HCC79	Seizure Disorders and Convulsions	0.069
HCC80	Coma, Brain Compression/Anoxic Damage	0.118
HCC82	Respirator Dependence/Tracheostomy Status	0.295
HCC83	Respiratory Arrest	0.114
HCC84	Cardio-Respiratory Failure and Shock	0.062
HCC85	Congestive Heart Failure	0.072
HCC86	Acute Myocardial Infarction	0.092
HCC87	Unstable Angina and Other Acute Ischemic Heart Disease	0.092
HCC88	Angina Pectoris	0.044
HCC96	Specified Heart Arrhythmias	0.071
HCC99	Cerebral Hemorrhage	0.077
HCC100	Ischemic or Unspecified Stroke	0.077
HCC103	Hemiplegia/Hemiparesis	0.076
HCC104	Monoplegia, Other Paralytic Syndromes	0.076
HCC106	Atherosclerosis of the Extremities with Ulceration or Gangrene	0.279
HCC107	Vascular Disease with Complications	0.084
HCC108	Vascular Disease	0.051
HCC110	Cystic Fibrosis	0.065
HCC111	Chronic Obstructive Pulmonary Disease	0.065
HCC112	Fibrosis of Lung and Other Chronic Lung Disorders	0.054
HCC114	Aspiration and Specified Bacterial Pneumonias	0.081
HCC115	Pneumococcal Pneumonia, Empyema, Lung Abscess	0.015
HCC122	Proliferative Diabetic Retinopathy and Vitreous Hemorrhage	-
HCC124	Exudative Macular Degeneration	-
HCC157	Pressure Ulcer of Skin with Necrosis Through to Muscle, Tendon, or Bone	0.171
HCC158	Pressure Ulcer of Skin with Full Thickness Skin Loss	0.171
HCC159	Pressure Ulcer of Skin with Partial Thickness Skin Loss	0.171
HCC160	Pressure Pre-Ulcer Skin Changes or Unspecified Stage	0.171
HCC161	Chronic Ulcer of Skin, Except Pressure	0.118
HCC162	Severe Skin Burn or Condition	0.049
HCC166	Severe Head Injury	0.118
HCC167	Major Head Injury	0.015
HCC169	Vertebral Fractures without Spinal Cord Injury	0.050
HCC170	Hip Fracture/Dislocation	0.040
HCC173	Traumatic Amputations and Complications	0.041
HCC176	Complications of Specified Implanted Device or Graft	-
HCC186	Major Organ Transplant or Replacement Status	0.159
HCC188	Artificial Openings for Feeding or Elimination	0.047
HCC189	Amputation Status, Lower Limb/Amputation Complications	0.114
Disease Interactions		
SEPSIS_CARD_RESP_FAIL	Sepsis*Cardiorespiratory Failure	0.100
CANCER_IMMUNE	Cancer*Immune Disorders	0.093
DIABETES_CHF	Diabetes*Congestive Heart Failure	0.020
CHF_COPD	Congestive Heart Failure*Chronic Obstructive Pulmonary Disease	0.018
COPD_CARD_RESP_FAIL	Chronic Obstructive Pulmonary Disease*Cardiorespiratory Failure	0.013
NonAged (Age <65)/Disease Interactions		
NONAGED_HCC6	NonAged, Opportunistic Infections	0.074
NONAGED_HCC34	NonAged, Chronic Pancreatitis	0.116
NONAGED_HCC46	NonAged, Severe Hematological Disorders	0.038
NONAGED_HCC54	NonAged, Drug/Alcohol Psychosis	0.166
NONAGED_HCC55	NonAged, Drug/Alcohol Dependence	0.166
NONAGED_HCC110	NonAged, Cystic Fibrosis	0.369
NONAGED_HCC176	NonAged, Complications of Specified Implanted Device or Graft	0.046

NOTES:
1. The CMS ESRD Dialysis Denominator used to calculate the relative factors is $75,564.91.

[2] Originally Disabled indicates beneficiary originally entered Medicare due to a condition other than ESRD.

[3] Originally ESRD indicates beneficiary originally entered Medicare due to ESRD. Beneficiaries that are Originally ESRD cannot be Originally Disabled.

The estimate for HCC 160 is based on pressure ulcer, any stage, for all anatomical sites codes. The estimated coefficient for HCC 160 is also assigned to HCCs 157, 158, and 159 in the constrained regression because the ICD9 codes for the stages of pressure ulcers are not implemented until FY09.

In the "disease interactions," the variables are defined as follows:
Sepsis = HCC 2.
Cardiorespiratory Failure = HCCs 82-84.
Cancer = HCCs 8-12.
Immune Disorders = HCC 47.
Diabetes = HCCs 17, 18, 19.
Congestive Heart Failure = HCC 85.
Chronic Obstructive Pulmonary Disease = HCCs 110-111.

SOURCE: RTI International analysis of 2006/2007 Medicare 100% ESRD sample claims and enrollment data.

Table 2. ESRD Model Demographic Relative Factors for New Enrollees in Dialysis Status

	Non-Medicaid & Non-Originally Disabled	Medicaid & Non-Originally Disabled	Non-Medicaid & Originally Disabled	Medicaid & Originally Disabled
Female				
0-34 Years	0.848	0.966	1.075	1.193
35-44 Years	0.848	0.966	1.075	1.193
45-54 Years	0.848	0.966	1.075	1.193
55-59 Years	0.883	1.001	1.110	1.228
60-64 Years	0.902	1.020	1.128	1.246
65-69 Years	1.021	1.120	1.248	1.347
70-74 Years	1.065	1.165	1.292	1.392
75-79 Years	1.123	1.222	1.350	1.449
80-84 Years	1.128	1.227	1.354	1.454
85 Years or Over	1.142	1.241	1.369	1.468
Male				
0-34 Years	0.735	0.842	0.957	1.065
35-44 Years	0.775	0.883	0.998	1.105
45-54 Years	0.811	0.919	1.034	1.141
55-59 Years	0.843	0.951	1.066	1.173
60-64 Years	0.867	0.975	1.090	1.197
65-69 Years	0.974	1.088	1.197	1.311
70-74 Years	1.030	1.144	1.253	1.367
75-79 Years	1.072	1.186	1.295	1.409
80-84 Years	1.105	1.219	1.327	1.441
85 Years or Over	1.120	1.234	1.342	1.456

NOTES:

1. The CMS ESRD Dialysis Denominator used to calculate the relative factors is $75,564.91.

2. Originally disabled terms refer to people originally entitled to Medicare for reasons of disability other than ESRD.

SOURCE: RTI International analysis of 2006/2007 Medicare 100% ESRD sample claims and enrollment data.

Table 3. ESRD Kidney Transplant CMS-HCC Model Relative Factors for Transplant Beneficiaries

	Beneficiaries	**Kidney Transplant** *Actual Dollars*	**Kidney Transplant Relative Risk Factor**
Month 1	8,412	36,618.30	5.815
Months 2 and 3	16,188	5,540.51	0.880
Total (Actual Months 1-3)		**47,569.19**	

NOTES:

1. Kidney transplant is identified by DRG 302 for discharge dates through September 30, 2007 and by MS-DRG 652 for discharge dates from October 1, 2007 on.

2. The transplant month payments were computed by aggregating the costs for each of the three monthly payments.

3. The transplant factor is calculated in this manner: (kidney transplant month's dollars/Dialysis Denominator)*12. The CMS ESRD Dialysis Denominator value used was $75,564.91.

SOURCE: RTI International analysis of 2006/2007 Medicare 100% ESRD sample claims and enrollment data.

Table 4. ESRD Model Functioning Graft Relative Factors for Community Population

Variable	Relative Factor
Functioning Graft Factors	
Aged 65+, with duration since transplant of 4-9 months	2.635
Aged <65, with duration since transplant of 4-9 months	2.582
Aged 65+, with duration since transplant of 10 months or more	1.268
Aged <65, with duration since transplant of 10 months or more	1.170
Female	
0-34 Years	0.198
35-44 Years	0.212
45-54 Years	0.274
55-59 Years	0.359
60-64 Years	0.416
65-69 Years	0.283
70-74 Years	0.346
75-79 Years	0.428
80-84 Years	0.517
85-89 Years	0.632
90-94 Years	0.755
95 Years or Over	0.775
Male	
0-34 Years	0.079
35-44 Years	0.119
45-54 Years	0.165
55-59 Years	0.292
60-64 Years	0.332
65-69 Years	0.309
70-74 Years	0.378
75-79 Years	0.464
80-84 Years	0.565
85-89 Years	0.647
90-94 Years	0.776
95 Years or Over	0.963
Medicaid and Originally Disabled Interactions with Age and Sex	
Medicaid_Female_Aged	0.213
Medicaid_Female_NonAged (Age <65)	0.104
Medicaid_Male_Aged	0.210
Medicaid_Male_NonAged (Age <65)	0.113
Originally Disabled_Female_Age ≥65	0.244
Originally Disabled_Male_Age ≥65	0.171

Disease Group	Description Label	Relative Factor
HCC1	HIV/AIDS	0.492
HCC2	Septicemia, Sepsis, Systemic Inflammatory Response Syndrome/Shock	0.520
HCC6	Opportunistic Infections	0.557
HCC8	Metastatic Cancer and Acute Leukemia	2.425
HCC9	Lung and Other Severe Cancers	1.006
HCC10	Lymphoma and Other Cancers	0.695
HCC11	Colorectal, Bladder, and Other Cancers	0.330
HCC12	Breast, Prostate, and Other Cancers and Tumors	0.180
HCC17	Diabetes with Acute Complications	0.344
HCC18	Diabetes with Chronic Complications	0.344
HCC19	Diabetes without Complication	0.124
HCC21	Protein-Calorie Malnutrition	0.653
HCC22	Morbid Obesity	0.342
HCC23	Other Significant Endocrine and Metabolic Disorders	0.240
HCC27	End-Stage Liver Disease	1.003
HCC28	Cirrhosis of Liver	0.425
HCC29	Chronic Hepatitis	0.313
HCC33	Intestinal Obstruction/Perforation	0.337
HCC34	Chronic Pancreatitis	0.257
HCC35	Inflammatory Bowel Disease	0.279
HCC39	Bone/Joint/Muscle Infections/Necrosis	0.423
HCC40	Rheumatoid Arthritis and Inflammatory Connective Tissue Disease	0.376
HCC46	Severe Hematological Disorders	1.078
HCC47	Disorders of Immunity	0.306
HCC48	Coagulation Defects and Other Specified Hematological Disorders	0.258

Disease Group	Description Label	Relative Factor
HCC51	Dementia With Complications	0.616
HCC52	Dementia Without Complication	0.343
HCC54	Drug/Alcohol Psychosis	0.358
HCC55	Drug/Alcohol Dependence	0.358
HCC57	Schizophrenia	0.471
HCC58	Major Depressive, Bipolar, and Paranoid Disorders	0.318
HCC70	Quadriplegia	1.075
HCC71	Paraplegia	0.868
HCC72	Spinal Cord Disorders/Injuries	0.441
HCC73	Amyotrophic Lateral Sclerosis and Other Motor Neuron Disease	1.016
HCC74	Cerebral Palsy	0.036
HCC75	Polyneuropathy	0.281
HCC76	Muscular Dystrophy	0.460
HCC77	Multiple Sclerosis	0.482
HCC78	Parkinson's and Huntington's Diseases	0.555
HCC79	Seizure Disorders and Convulsions	0.252
HCC80	Coma, Brain Compression/Anoxic Damage	0.533
HCC82	Respirator Dependence/Tracheostomy Status	1.732
HCC83	Respiratory Arrest	0.769
HCC84	Cardio-Respiratory Failure and Shock	0.326
HCC85	Congestive Heart Failure	0.361
HCC86	Acute Myocardial Infarction	0.283
HCC87	Unstable Angina and Other Acute Ischemic Heart Disease	0.283
HCC88	Angina Pectoris	0.210
HCC96	Specified Heart Arrhythmias	0.276
HCC99	Cerebral Hemorrhage	0.371
HCC100	Ischemic or Unspecified Stroke	0.333
HCC103	Hemiplegia/Hemiparesis	0.481
HCC104	Monoplegia, Other Paralytic Syndromes	0.212
HCC106	Atherosclerosis of the Extremities with Ulceration or Gangrene	1.313
HCC107	Vascular Disease with Complications	0.417
HCC108	Vascular Disease	0.288
HCC110	Cystic Fibrosis	0.388
HCC111	Chronic Obstructive Pulmonary Disease	0.388
HCC112	Fibrosis of Lung and Other Chronic Lung Disorders	0.294
HCC114	Aspiration and Specified Bacterial Pneumonias	0.691
HCC115	Pneumococcal Pneumonia, Empyema, Lung Abscess	0.212
HCC122	Proliferative Diabetic Retinopathy and Vitreous Hemorrhage	0.223
HCC124	Exudative Macular Degeneration	0.248
HCC134	Dialysis Status	—
HCC135	Acute Renal Failure	—
HCC136	Chronic Kidney Disease, Stage 5	—
HCC137	Chronic Kidney Disease, Severe (Stage 4)	—
HCC138	Chronic Kidney Disease, Moderate (Stage 3)	—
HCC139	Chronic Kidney Disease, Mild or Unspecified (Stages 1-2 or Unspecified)	—
HCC140	Unspecified Renal Failure	—
HCC141	Nephritis	—
HCC157	Pressure Ulcer of Skin with Necrosis Through to Muscle, Tendon, or Bone	1.071
HCC158	Pressure Ulcer of Skin with Full Thickness Skin Loss	1.071
HCC159	Pressure Ulcer of Skin with Partial Thickness Skin Loss	1.071
HCC160	Pressure Pre-Ulcer Skin Changes or Unspecified Stage	1.071
HCC161	Chronic Ulcer of Skin, Except Pressure	0.473
HCC162	Severe Skin Burn or Condition	0.458
HCC166	Severe Head Injury	0.533
HCC167	Major Head Injury	0.141
HCC169	Vertebral Fractures without Spinal Cord Injury	0.441
HCC170	Hip Fracture/Dislocation	0.363
HCC173	Traumatic Amputations and Complications	0.379
HCC176	Complications of Specified Implanted Device or Graft	0.668
HCC186	Major Organ Transplant or Replacement Status	0.203
HCC188	Artificial Openings for Feeding or Elimination	0.609
HCC189	Amputation Status, Lower Limb/Amputation Complications	0.804

Disease Group	Description Label	Relative Factor
Disease Interactions		
SEPSIS_CARD_RESP_FAIL	Sepsis*Cardiorespiratory Failure	0.634
CANCER_IMMUNE	Cancer*Immune Disorders	1.101
DIABETES_CHF	Diabetes*Congestive Heart Failure	0.237
CHF_COPD	Congestive Heart Failure*Chronic Obstructive Pulmonary Disease	0.255
CHF_RENAL	Congestive Heart Failure*Renal Disease	—
COPD_CARD_RESP_FAIL	Chronic Obstructive Pulmonary Disease*Cardiorespiratory Failure	0.420
NonAged (Age <65)/Disease Interactions		
NONAGED_HCC6	NonAged, Opportunistic Infections	0.564
NONAGED_HCC34	NonAged, Chronic Pancreatitis	0.757
NONAGED_HCC46	NonAged, Severe Hematological Disorders	0.818
NONAGED_HCC54	NonAged, Drug/Alcohol Psychosis	0.432
NONAGED_HCC55	NonAged, Drug/Alcohol Dependence	0.147
NONAGED_HCC110	NonAged, Cystic Fibrosis	2.397
NONAGED_HCC176	NonAged, Complications of Specified Implanted Device or Graft	—

NOTES:

1. The coefficients estimated for this model are the Functioning Graft add-on factors for being in a month after the 3 months accounted for in the Transplant segment of the ESRD system. Early months post-transplant incur higher Medicare spending than later months. The model differentiates the six months, months 4-9, from months further from the transplant period.

2. Originally disabled terms refer to people originally entitled to Medicare for reasons of disability other than ESRD.

3. The Denominator used to calculate the relative factors is $8,034.71.

In the "disease interactions," the variables are defined as follows:

Sepsis = HCC 2.
Cardiorespiratory Failure = HCCs 82-84.
Cancer = HCCs 8-12.
Immune Disorders = HCC 47.
Diabetes = HCCs 17, 18, 19.
Congestive Heart Failure = HCC 85.
Chronic Obstructive Pulmonary Disease = HCCs 110-111.
Renal Disease = HCCs 134-141.

SOURCE: RTI International analysis of 2006/2007 100% ESRD sample claims and enrollment data and 2006/2007 Medicare 5% sample.

Table 5. ESRD Model Functioning Graft Relative Factors for Institutionalized Population

Variable	Relative Factor
Functioning Graft Factors	
Aged 65+, with duration since transplant of 4-9 months	2.635
Aged <65, with duration since transplant of 4-9 months	2.582
Aged 65+, with duration since transplant of 10 months or more	1.268
Aged <65, with duration since transplant of 10 months or more	1.170
Female	
0-34 Years	0.783
35-44 Years	0.723
45-54 Years	0.700
55-59 Years	0.805
60-64 Years	0.773
65-69 Years	1.004
70-74 Years	0.947
75-79 Years	0.874
80-84 Years	0.792
85-89 Years	0.699
90-94 Years	0.594
95 Years or Over	0.465
Male	
0-34 Years	0.994
35-44 Years	0.658
45-54 Years	0.687
55-59 Years	0.814
60-64 Years	0.877
65-69 Years	1.148
70-74 Years	1.195
75-79 Years	1.168
80-84 Years	1.104
85-89 Years	1.046
90-94 Years	0.928
95 Years or Over	0.842
Medicaid and Originally Disabled Interactions with Age and Sex	
Medicaid	0.126
Originally Disabled_Age ≥65	0.026

Disease Group	Description Label	Relative Factor
HCC1	HIV/AIDS	1.374
HCC2	Septicemia, Sepsis, Systemic Inflammatory Response Syndrome/Shock	0.471
HCC6	Opportunistic Infections	0.541
HCC8	Metastatic Cancer and Acute Leukemia	0.928
HCC9	Lung and Other Severe Cancers	0.610
HCC10	Lymphoma and Other Cancers	0.363
HCC11	Colorectal, Bladder, and Other Cancers	0.255
HCC12	Breast, Prostate, and Other Cancers and Tumors	0.165
HCC17	Diabetes with Acute Complications	0.434
HCC18	Diabetes with Chronic Complications	0.434
HCC19	Diabetes without Complication	0.187
HCC21	Protein-Calorie Malnutrition	0.343
HCC22	Morbid Obesity	0.353
HCC23	Other Significant Endocrine and Metabolic Disorders	0.248
HCC27	End-Stage Liver Disease	0.637
HCC28	Cirrhosis of Liver	0.343
HCC29	Chronic Hepatitis	0.343
HCC33	Intestinal Obstruction/Perforation	0.302
HCC34	Chronic Pancreatitis	0.175
HCC35	Inflammatory Bowel Disease	0.250
HCC39	Bone/Joint/Muscle Infections/Necrosis	0.386
HCC40	Rheumatoid Arthritis and Inflammatory Connective Tissue Disease	0.222
HCC46	Severe Hematological Disorders	0.638
HCC47	Disorders of Immunity	0.436
HCC48	Coagulation Defects and Other Specified Hematological Disorders	0.197
HCC51	Dementia With Complications	—

Disease Group	Description Label	Relative Factor
HCC52	Dementia Without Complication	—
HCC54	Drug/Alcohol Psychosis	0.051
HCC55	Drug/Alcohol Dependence	0.051
HCC57	Schizophrenia	0.274
HCC58	Major Depressive, Bipolar, and Paranoid Disorders	0.274
HCC70	Quadriplegia	0.497
HCC71	Paraplegia	0.497
HCC72	Spinal Cord Disorders/Injuries	0.191
HCC73	Amyotrophic Lateral Sclerosis and Other Motor Neuron Disease	0.294
HCC74	Cerebral Palsy	—
HCC75	Polyneuropathy	0.256
HCC76	Muscular Dystrophy	0.247
HCC77	Multiple Sclerosis	—
HCC78	Parkinson's and Huntington's Diseases	0.110
HCC79	Seizure Disorders and Convulsions	0.173
HCC80	Coma, Brain Compression/Anoxic Damage	0.103
HCC82	Respirator Dependence/Tracheostomy Status	1.567
HCC83	Respiratory Arrest	0.611
HCC84	Cardio-Respiratory Failure and Shock	0.346
HCC85	Congestive Heart Failure	0.226
HCC86	Acute Myocardial Infarction	0.394
HCC87	Unstable Angina and Other Acute Ischemic Heart Disease	0.394
HCC88	Angina Pectoris	0.366
HCC96	Specified Heart Arrhythmias	0.227
HCC99	Cerebral Hemorrhage	0.175
HCC100	Ischemic or Unspecified Stroke	0.175
HCC103	Hemiplegia/Hemiparesis	0.063
HCC104	Monoplegia, Other Paralytic Syndromes	0.063
HCC106	Atherosclerosis of the Extremities with Ulceration or Gangrene	0.773
HCC107	Vascular Disease with Complications	0.257
HCC108	Vascular Disease	0.146
HCC110	Cystic Fibrosis	0.323
HCC111	Chronic Obstructive Pulmonary Disease	0.323
HCC112	Fibrosis of Lung and Other Chronic Lung Disorders	0.252
HCC114	Aspiration and Specified Bacterial Pneumonias	0.239
HCC115	Pneumococcal Pneumonia, Empyema, Lung Abscess	0.194
HCC122	Proliferative Diabetic Retinopathy and Vitreous Hemorrhage	0.366
HCC124	Exudative Macular Degeneration	0.178
HCC134	Dialysis Status	—
HCC135	Acute Renal Failure	—
HCC136	Chronic Kidney Disease, Stage 5	—
HCC137	Chronic Kidney Disease, Severe (Stage 4)	—
HCC138	Chronic Kidney Disease, Moderate (Stage 3)	—
HCC139	Chronic Kidney Disease, Mild or Unspecified (Stages 1-2 or Unspecified)	—
HCC140	Unspecified Renal Failure	—
HCC141	Nephritis	—
HCC157	Pressure Ulcer of Skin with Necrosis Through to Muscle, Tendon, or Bone	0.284
HCC158	Pressure Ulcer of Skin with Full Thickness Skin Loss	0.284
HCC159	Pressure Ulcer of Skin with Partial Thickness Skin Loss	0.284
HCC160	Pressure Pre-Ulcer Skin Changes or Unspecified Stage	0.284
HCC161	Chronic Ulcer of Skin, Except Pressure	0.226
HCC162	Severe Skin Burn or Condition	—
HCC166	Severe Head Injury	0.103
HCC167	Major Head Injury	—
HCC169	Vertebral Fractures without Spinal Cord Injury	0.179
HCC170	Hip Fracture/Dislocation	—
HCC173	Traumatic Amputations and Complications	0.067
HCC176	Complications of Specified Implanted Device or Graft	0.668
HCC186	Major Organ Transplant or Replacement Status	0.203
HCC188	Artificial Openings for Feeding or Elimination	0.658
HCC189	Amputation Status, Lower Limb/Amputation Complications	0.384
Disease Interactions		
CHF_COPD	Congestive Heart Failure*Chronic Obstructive Pulmonary Disease	0.159
CRFAIL_COPD	Cardiorespiratory Failure*Chronic Obstructive Pulmonary Disease	0.524
SEPSIS_PRESSURE_ULCER	Sepsis*Pressure Ulcer	0.538
SEPSIS_ARTIF_OPENINGS	Sepsis*Artificial Openings for Feeding or Elimination	0.453

Disease Group	Description Label	Relative Factor
ARTIF_OPENINGS_PRESSURE_ULCER	Artificial Openings for Feeding or Elimination*Pressure Ulcer	0.361
DIABETES_CHF	Diabetes*Congestive Heart Failure	0.143
COPD_ASP_SPEC_BACT_PNEUM	Chronic Obstructive Pulmonary Disease*Aspiration and Specified Bacterial Pneumonias	0.249
ASP_SPEC_BACT_PNEUM_PRES_ULCER	Aspiration and Specified Bacterial Pneumonias*Pressure Ulcer	0.325
SEPSIS_ASP_SPEC_BACT_PNEUM	Sepsis*Aspiration and Specified Bacterial Pneumonias	0.387
SCHIZOPHRENIA_COPD	Schizophrenia*Chronic Obstructive Pulmonary Disease	0.187
SCHIZOPHRENIA_CHF	Schizophrenia*Congestive Heart Failure	0.220
SCHIZOPHRENIA_SEIZURES	Schizophrenia*Seizure Disorders and Convulsions	0.303
NonAged (Age <65)/Disease Interactions		
NONAGED_HCC85	NonAged, Congestive Heart Failure	0.320
NONAGED_PRESSURE_ULCER	NonAged, Pressure Ulcer	0.421
NONAGED_HCC161	NonAged, Chronic Ulcer of the Skin, Except Pressure Ulcer	0.337
NONAGED_HCC39	NonAged, Bone/Joint Muscle Infections/Necrosis	0.624
NONAGED_HCC77	NonAged, Multiple Sclerosis	0.344
NONAGED_HCC6	NonAged, Opportunistic Infections	0.914

NOTES:

1. The coefficients estimated for this model are the Functioning Graft add-on factors for being in a month after the 3 months accounted for in the Transplant segment of the ESRD system. Early months post-transplant incur higher Medicare spending than later months. The model differentiates the six months, months 4-9, from months further from the transplant period.

2. Originally disabled terms refer to people originally entitled to Medicare for reasons of disability other than ESRD.

3. The Denominator used to calculate the relative factors is $8,034.71.

In the "Disease interactions" and "NonAged interactions," the variables are defined as follows:

Sepsis = HCC 2.
Cardiorespiratory Failure = HCCs 82-84.
Diabetes = HCCs 17, 18, 19.
Congestive Heart Failure = HCC 85.
Chronic Obstructive Pulmonary Disease = HCCs 110-111.
Pressure Ulcer = HCCs 157-160.
Artificial Openings for Feeding or Elimination = HCC 188.
Aspiration and Specified Bacterial Pneumonias = HCC 114.
Schizophrenia = HCC 57.
Seizure Disorders and Convulsions = HCC 79.
Chronic Ulcer of Skin, except Pressure = HCC 161.
Bone/Joint/Muscle Infections/Necrosis = HCC 39.
Multiple Sclerosis = HCC 77.
Opportunistic Infections = HCC 6.

SOURCE: RTI International analysis of 2006/2007 100% ESRD sample claims and enrollment data and 2006/2007 Medicare 5% sample.

Table 6. ESRD Model Demographic Relative Factors for Functioning Graft New Enrollees Duration Since Transplant of 4-9 Months

	Non-Medicaid & Non-Originally Disabled	Medicaid & Non-Originally Disabled	Non-Medicaid & Originally Disabled	Medicaid & Originally Disabled
Female				
0-34 Years	3.033	3.362	–	–
35-44 Years	3.180	3.509	–	–
45-54 Years	3.388	3.717	–	–
55-59 Years	3.554	3.883	–	–
60-64 Years	3.659	3.988	–	–
65 Years	3.133	3.644	3.753	4.263
66 Years	3.174	3.646	3.821	4.292
67 Years	3.210	3.682	3.857	4.328
68 Years	3.229	3.701	3.876	4.347
69 Years	3.256	3.727	3.902	4.373
70-74 Years	3.368	3.862	3.955	4.449
75-79 Years	3.571	3.994	4.130	4.553
80-84 Years	3.745	4.169	4.304	4.728
85-89 Years	3.908	4.332	4.467	4.891
90-94 Years	4.000	4.423	4.559	4.982
95 Years or Over	3.875	4.298	4.434	4.858
Male				
0-34 Years	2.824	3.241	–	–
35-44 Years	3.030	3.446	–	–
45-54 Years	3.212	3.628	–	–
55-59 Years	3.403	3.819	–	–
60-64 Years	3.533	3.950	–	–
65 Years	3.174	3.726	3.738	4.289
66 Years	3.232	3.783	3.751	4.302
67 Years	3.262	3.813	3.781	4.332
68 Years	3.290	3.842	3.809	4.361
69 Years	3.311	3.863	3.830	4.382
70-74 Years	3.449	4.000	3.965	4.515
75-79 Years	3.685	4.195	4.124	4.635
80-84 Years	3.904	4.414	4.343	4.853
85-89 Years	4.074	4.584	4.513	5.023
90-94 Years	4.249	4.759	4.688	5.198
95 Years or Over	4.315	4.826	4.754	5.265

NOTES:
1. The table entries are derived from the Graft New Enrollee model. 2. Originally Disabled terms refer to people originally entitled to Medicare for reasons of disability other than ESRD. In this model, Originally Disabled is defined only for beneficiaries age 65 and greater.

3. The Denominator used to calculate the relative factors is $8,034.71.

SOURCE: RTI International analysis of 2006/2007 100% ESRD sample claims and enrollment data and 2006/2007 Medicare 5% sample.

Table 7. ESRD Model Demographic Relative Factors for Functioning Graft New Enrollees Duration Since Transplant of 10 Months or More

	Non-Medicaid & Non-Originally Disabled	Medicaid & Non-Originally Disabled	Non-Medicaid & Originally Disabled	Medicaid & Originally Disabled
Female				
0-34 Years	1.621	1.951	–	–
35-44 Years	1.768	2.098	–	–
45-54 Years	1.976	2.306	–	–
55-59 Years	2.142	2.472	–	–
60-64 Years	2.247	2.577	–	–
65 Years	1.766	2.277	2.386	2.896
66 Years	1.808	2.279	2.454	2.925
67 Years	1.844	2.315	2.490	2.961
68 Years	1.862	2.334	2.509	2.980
69 Years	1.889	2.360	2.535	3.006
70-74 Years	2.001	2.495	2.588	3.082
75-79 Years	2.204	2.627	2.763	3.186
80-84 Years	2.378	2.802	2.938	3.361
85-89 Years	2.541	2.965	3.101	3.524
90-94 Years	2.633	3.056	3.192	3.615
95 Years or Over	2.508	2.931	3.067	3.491
Male				
0-34 Years	1.412	1.829	–	–
35-44 Years	1.618	2.035	–	–
45-54 Years	1.800	2.217	–	–
55-59 Years	1.991	2.408	–	–
60-64 Years	2.122	2.538	–	–
65 Years	1.807	2.359	2.371	2.922
66 Years	1.865	2.416	2.384	2.935
67 Years	1.895	2.446	2.414	2.965
68 Years	1.924	2.475	2.442	2.994
69 Years	1.944	2.496	2.463	3.015
70-74 Years	2.082	2.633	2.598	3.149
75-79 Years	2.318	2.829	2.757	3.268
80-84 Years	2.537	3.047	2.976	3.486
85-89 Years	2.707	3.217	3.146	3.657
90-94 Years	2.882	3.392	3.321	3.831
95 Years or Over	2.948	3.459	3.387	3.898

NOTES:
1. The table entries are derived from the Graft New Enrollee model. 2. Originally Disabled terms refer to people originally entitled to Medicare for reasons of disability other than ESRD. In this model, Originally Disabled is defined only for beneficiaries age 65 and greater.

3. The Denominator used to calculate the relative factors is $8,034.71.

SOURCE: RTI International analysis of 2006/2007 100% ESRD sample claims and enrollment data and 2006/2007 Medicare 5% sample.

Table 8. List of Disease Hierarchies for the Revised ESRD Model

DISEASE HIERARCHIES

Hierarchical Condition Category (HCC)	If the Disease Group is Listed in this column…	…Then drop the HCC(s) listed in this column
	Hierarchical Condition Category (HCC) LABEL	
8	Metastatic Cancer and Acute Leukemia	9,10,11,12
9	Lung and Other Severe Cancers	10,11,12
10	Lymphoma and Other Cancers	11,12
11	Colorectal, Bladder, and Other Cancers	12
17	Diabetes with Acute Complications	18,19
18	Diabetes with Chronic Complications	19
27	End-Stage Liver Disease	28,29,80
28	Cirrhosis of Liver	29
46	Severe Hematological Disorders	48
51	Dementia With Complications	52
54	Drug/Alcohol Psychosis	55
57	Schizophrenia	58
70	Quadriplegia	71,72,103,104,169
71	Paraplegia	72,104,169
72	Spinal Cord Disorders/Injuries	169
82	Respirator Dependence/Tracheostomy Status	83,84
83	Respiratory Arrest	84
86	Acute Myocardial Infarction	87,88
87	Unstable Angina and Other Acute Ischemic Heart Disease	88
99	Cerebral Hemorrhage	100
103	Hemiplegia/Hemiparesis	104
106	Atherosclerosis of the Extremities with Ulceration or Gangrene	107,108,161,189
107	Vascular Disease with Complications	108
110	Cystic Fibrosis	111,112
111	Chronic Obstructive Pulmonary Disease	112
114	Aspiration and Specified Bacterial Pneumonias	115
134	Dialysis Status	135,136,137,138,139,140,141
135	Acute Renal Failure	136,137,138,139,140,141
136	Chronic Kidney Disease, Stage 5	137,138,139,140,141
137	Chronic Kidney Disease, Severe (Stage 4)	138,139,140,141
138	Chronic Kidney Disease, Moderate (Stage 3)	139,140,141
139	Chronic Kidney Disease, Mild or Unspecified (Stages 1-2 or Unspecified)	140,141
140	Unspecified Renal Failure	141
157	Pressure Ulcer of Skin with Necrosis Through to Muscle, Tendon, or Bone	158,159,160,161
158	Pressure Ulcer of Skin with Full Thickness Skin Loss	159,160,161
159	Pressure Ulcer of Skin with Partial Thickness Skin Loss	160,161
160	Pressure Pre-Ulcer Skin Changes or Unspecified Stage	161
166	Severe Head Injury	80,167

How Payments are Made with a Disease Hierarchy EXAMPLE: If a beneficiary triggers HCCs 140 (Unspecified Renal Failure) and 141 (Nephritis), then HCC 141 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 organization's payment will be based on HCC 140 rather than HCC 141.

Table 9. Community and Institutional Relative Factors for the Revised CMS-HCC Risk Adjustment Model

Variable	Disease Group	Community Factor	Institutional Factor
Female			
0-34 Years		0.198	0.783
35-44 Years		0.212	0.723
45-54 Years		0.274	0.700
55-59 Years		0.359	0.805
60-64 Years		0.416	0.773
65-69 Years		0.283	1.004
70-74 Years		0.346	0.947
75-79 Years		0.428	0.874
80-84 Years		0.517	0.792
85-89 Years		0.632	0.699
90-94 Years		0.755	0.594
95 Years or Over		0.775	0.465
Male			
0-34 Years		0.079	0.994
35-44 Years		0.119	0.658
45-54 Years		0.165	0.687
55-59 Years		0.292	0.814
60-64 Years		0.332	0.877
65-69 Years		0.309	1.148
70-74 Years		0.378	1.195
75-79 Years		0.464	1.168
80-84 Years		0.565	1.104
85-89 Years		0.647	1.046
90-94 Years		0.776	0.928
95 Years or Over		0.963	0.842
Medicaid and Originally Disabled Interactions with Age and Sex			
Medicaid_Female_Aged		0.213	
Medicaid_Female_Disabled		0.104	
Medicaid_Male_Aged		0.210	
Medicaid_Male_Disabled		0.113	
Originally Disabled_Female		0.244	
Originally Disabled_Male		0.171	
Medicaid and Originally Disabled			
Medicaid			0.126
Originally Disabled			0.026

Disease Coefficients	Description Label	Community Factor	Institutional Factor
HCC1	HIV/AIDS	0.492	1.374
HCC2	Septicemia, Sepsis, Systemic Inflammatory Response Syndrome/Shock	0.520	0.471
HCC6	Opportunistic Infections	0.557	0.541
HCC8	Metastatic Cancer and Acute Leukemia	2.425	0.928
HCC9	Lung and Other Severe Cancers	1.006	0.610
HCC10	Lymphoma and Other Cancers	0.695	0.363
HCC11	Colorectal, Bladder, and Other Cancers	0.330	0.255
HCC12	Breast, Prostate, and Other Cancers and Tumors	0.180	0.165
HCC17	Diabetes with Acute Complications	0.344	0.434
HCC18	Diabetes with Chronic Complications	0.344	0.434
HCC19	Diabetes without Complication	0.124	0.187
HCC21	Protein-Calorie Malnutrition	0.653	0.343
HCC22	Morbid Obesity	0.342	0.353
HCC23	Other Significant Endocrine and Metabolic Disorders	0.240	0.248
HCC27	End-Stage Liver Disease	1.003	0.637
HCC28	Cirrhosis of Liver	0.425	0.343
HCC29	Chronic Hepatitis	0.313	0.343
HCC33	Intestinal Obstruction/Perforation	0.337	0.302
HCC34	Chronic Pancreatitis	0.257	0.175
HCC35	Inflammatory Bowel Disease	0.279	0.250

Disease Coefficients	Description Label	Community Factor	Institutional Factor
HCC39	Bone/Joint/Muscle Infections/Necrosis	0.423	0.386
HCC40	Rheumatoid Arthritis and Inflammatory Connective Tissue Disease	0.376	0.222
HCC46	Severe Hematological Disorders	1.078	0.638
HCC47	Disorders of Immunity	0.306	0.436
HCC48	Coagulation Defects and Other Specified Hematological Disorders	0.258	0.197
HCC51	Dementia With Complications	0.616	—
HCC52	Dementia Without Complication	0.343	—
HCC54	Drug/Alcohol Psychosis	0.358	0.051
HCC55	Drug/Alcohol Dependence	0.358	0.051
HCC57	Schizophrenia	0.471	0.274
HCC58	Major Depressive, Bipolar, and Paranoid Disorders	0.318	0.274
HCC70	Quadriplegia	1.075	0.497
HCC71	Paraplegia	0.868	0.497
HCC72	Spinal Cord Disorders/Injuries	0.441	0.191
HCC73	Amyotrophic Lateral Sclerosis and Other Motor Neuron Disease	1.016	0.294
HCC74	Cerebral Palsy	0.036	—
HCC75	Polyneuropathy	0.281	0.256
HCC76	Muscular Dystrophy	0.460	0.247
HCC77	Multiple Sclerosis	0.482	—
HCC78	Parkinson's and Huntington's Diseases	0.555	0.110
HCC79	Seizure Disorders and Convulsions	0.252	0.173
HCC80	Coma, Brain Compression/Anoxic Damage	0.533	0.103
HCC82	Respirator Dependence/Tracheostomy Status	1.732	1.567
HCC83	Respiratory Arrest	0.769	0.611
HCC84	Cardio-Respiratory Failure and Shock	0.326	0.346
HCC85	Congestive Heart Failure	0.361	0.226
HCC86	Acute Myocardial Infarction	0.283	0.394
HCC87	Unstable Angina and Other Acute Ischemic Heart Disease	0.283	0.394
HCC88	Angina Pectoris	0.210	0.366
HCC96	Specified Heart Arrhythmias	0.276	0.227
HCC99	Cerebral Hemorrhage	0.371	0.175
HCC100	Ischemic or Unspecified Stroke	0.333	0.175
HCC103	Hemiplegia/Hemiparesis	0.481	0.063
HCC104	Monoplegia, Other Paralytic Syndromes	0.212	0.063
HCC106	Atherosclerosis of the Extremities with Ulceration or Gangrene	1.313	0.773
HCC107	Vascular Disease with Complications	0.417	0.257
HCC108	Vascular Disease	0.288	0.146
HCC110	Cystic Fibrosis	0.388	0.323
HCC111	Chronic Obstructive Pulmonary Disease	0.388	0.323
HCC112	Fibrosis of Lung and Other Chronic Lung Disorders	0.294	0.252
HCC114	Aspiration and Specified Bacterial Pneumonias	0.691	0.239
HCC115	Pneumococcal Pneumonia, Empyema, Lung Abscess	0.212	0.194
HCC122	Proliferative Diabetic Retinopathy and Vitreous Hemorrhage	0.223	0.366
HCC124	Exudative Macular Degeneration	0.248	0.178
HCC134	Dialysis Status	0.617	0.538
HCC135	Acute Renal Failure	0.617	0.538
HCC136	Chronic Kidney Disease, Stage 5	0.227	0.304
HCC137	Chronic Kidney Disease, Severe (Stage 4)	0.227	0.304
HCC138	Chronic Kidney Disease, Moderate (Stage 3)	0.227	0.304
HCC139	Chronic Kidney Disease, Mild or Unspecified (Stages 1-2 or Unspecified)	0.227	0.304
HCC140	Unspecified Renal Failure	0.227	0.304
HCC141	Nephritis	0.075	0.235
HCC157	Pressure Ulcer of Skin with Necrosis Through to Muscle, Tendon, or Bone	1.071	0.284
HCC158	Pressure Ulcer of Skin with Full Thickness Skin Loss	1.071	0.284

Disease Coefficients	Description Label	Community Factor	Institutional Factor
HCC159	Pressure Ulcer of Skin with Partial Thickness Skin Loss	1.071	0.284
HCC160	Pressure Pre-Ulcer Skin Changes or Unspecified Stage	1.071	0.284
HCC161	Chronic Ulcer of Skin, Except Pressure	0.473	0.226
HCC162	Severe Skin Burn or Condition	0.458	—
HCC166	Severe Head Injury	0.533	0.103
HCC167	Major Head Injury	0.141	—
HCC169	Vertebral Fractures without Spinal Cord Injury	0.441	0.179
HCC170	Hip Fracture/Dislocation	0.363	—
HCC173	Traumatic Amputations and Complications	0.379	0.067
HCC176	Complications of Specified Implanted Device or Graft	0.555	0.369
HCC186	Major Organ Transplant or Replacement Status	1.032	1.120
HCC188	Artificial Openings for Feeding or Elimination	0.609	0.658
HCC189	Amputation Status, Lower Limb/Amputation Complications	0.804	0.384
Disease Interactions			
SEPSIS CARD RESP FAIL	Sepsis*Cardiorespiratory Failure	0.634	
CANCER IMMUNE	Cancer*Immune Disorders	1.101	
DIABETES CHF	Diabetes*Congestive Heart Failure	0.237	0.143
CHF COPD	Congestive Heart Failure*Chronic Obstructive Pulmonary Disease	0.255	0.159
CHF RENAL	Congestive Heart Failure*Renal Disease	0.201	
COPD CARD RESP FAIL	Chronic Obstructive Pulmonary Disease*Cardiorespiratory Failure	0.420	
CRFAIL COPD	Cardiorespiratory Failure*Chronic Obstructive Pulmonary Disease		0.524
SEPSIS PRESSURE ULCER	Sepsis*Pressure Ulcer		0.538
SEPSIS ARTIF OPENINGS	Sepsis*Artificial Openings for Feeding or Elimination		0.453
ARTIF OPENINGS PRESSURE ULCER	Artificial Openings for Feeding or Elimination*Pressure Ulcer		0.361
COPD ASP SPEC BACT PNEUM	Chronic Obstructive Pulmonary Disease*Aspiration and Specified Bacterial Pneumonias		0.249
ASP SPEC BACT PNEUM PRES ULCER	Aspiration and Specified Bacterial Pneumonias*Pressure Ulcer		0.325
SEPSIS ASP SPEC BACT PNEUM	Sepsis*Aspiration and Specified Bacterial Pneumonias		0.387
SCHIZOPHRENIA COPD	Schizophrenia*Chronic Obstructive Pulmonary Disease		0.187
SCHIZOPHRENIA CHF	Schizophrenia*Congestive Heart Failure		0.220
SCHIZOPHRENIA SEIZURES	Schizophrenia*Seizure Disorders and Convulsions		0.303
Disabled/Disease Interactions			
DISABLED HCC6	Disabled, Opportunistic Infections	0.564	
DISABLED HCC34	Disabled, Chronic Pancreatitis	0.757	
DISABLED HCC46	Disabled, Severe Hematological Disorders	0.818	
DISABLED HCC54	Disabled, Drug/Alcohol Psychosis	0.432	
DISABLED HCC55	Disabled, Drug/Alcohol Dependence	0.147	
DISABLED HCC110	Disabled, Cystic Fibrosis	2.397	
DISABLED HCC176	Disabled, Complications of Specified Implanted Device or Graft	0.495	
DISABLED HCC85	Disabled, Congestive Heart Failure		0.320
DISABLED PRESSURE ULCER	Disabled, Pressure Ulcer		0.421
DISABLED HCC161	Disabled, Chronic Ulcer of the Skin, Except Pressure Ulcer		0.337
DISABLED HCC39	Disabled, Bone/Joint Muscle Infections/Necrosis		0.624
DISABLED HCC77	Disabled, Multiple Sclerosis		0.344
DISABLED HCC6	Disabled, Opportunistic Infections		0.914

NOTES

1. The relative risk scores in this table were calculated by dividing the parameter estimates by the Part C national average predicted expenditures (CMS Part C Denominator). The Part C Denominator value used is $8,034.71.

2. The relative factor for HCC 160 is based on pressure ulcer, any stage, for all anatomical sites codes. The relative factor for HCC 160 is also assigned to HCCs 157, 158, and 159 in the constrained regression because the ICD9 codes for the stages of pressure ulcers are not implemented until FY09.

In the "disease interactions," the variables are defined as follows:

Artificial Openings for Feeding or Elimination = HCC 188.
Aspiration and Specified Bacterial Pneumonias = HCC 114.
Bone/Joint/Muscle Infections/Necrosis = HCC 39.
Cancer = HCCs 8-12.
Cardiorespiratory Failure = HCCs 82-84.
Chronic Obstructive Pulmonary Disease = HCCs 110-111.
Chronic Ulcer of Skin, except Pressure = HCC 161.
Congestive Heart Failure = HCC 85.
Diabetes = HCCs 17, 18, 19.
Immune Disorders = HCC 47.
Multiple Sclerosis = HCC 77.
Opportunistic Infections = HCC 6.
Pressure Ulcer = HCCs 157-160.
Renal Disease = HCCs 134-141.
Schizophrenia = HCC 57.
Seizure Disorders and Convulsions = HCC 79.
Sepsis = HCC 2.

SOURCE: RTI International analysis of 2006/2007 Medicare 5% sample.
SOURCE: RTI International analysis of 2006/2007 Medicare 100% institutional sample.

Table 10. Revised CMS-HCC Model Relative Factors for Aged and Disabled New Enrollees

	Non-Medicaid & Non-Originally Disabled	Medicaid & Non-Originally Disabled	Non-Medicaid & Originally Disabled	Medicaid & Originally Disabled
Female				
0-34 Years	0.453	0.784	-	-
35-44 Years	0.601	0.932	-	-
45-54 Years	0.810	1.141	-	-
55-59 Years	0.977	1.308	-	-
60-64 Years	1.082	1.414	-	-
65 Years	0.501	1.014	1.124	1.637
66 Years	0.543	1.016	1.192	1.665
67 Years	0.579	1.052	1.228	1.702
68 Years	0.598	1.071	1.247	1.721
69 Years	0.624	1.098	1.274	1.747
70-74 Years	0.737	1.233	1.327	1.823
75-79 Years	0.941	1.366	1.503	1.928
80-84 Years	1.116	1.542	1.678	2.104
85-89 Years	1.280	1.706	1.842	2.268
90-94 Years	1.372	1.797	1.934	2.359
95 Years or Over	1.247	1.672	1.809	2.234
Male				
0-34 Years	0.243	0.662	-	-
35-44 Years	0.450	0.869	-	-
45-54 Years	0.633	1.052	-	-
55-59 Years	0.825	1.244	-	-
60-64 Years	0.956	1.375	-	-
65 Years	0.542	1.096	1.109	1.663
66 Years	0.601	1.155	1.122	1.676
67 Years	0.631	1.185	1.152	1.706
68 Years	0.659	1.213	1.181	1.735
69 Years	0.680	1.234	1.202	1.756
70-74 Years	0.818	1.372	1.337	1.890
75-79 Years	1.056	1.569	1.497	2.010
80-84 Years	1.275	1.788	1.717	2.230
85-89 Years	1.446	1.960	1.888	2.401
90-94 Years	1.622	2.135	2.063	2.577
95 Years or Over	1.689	2.202	2.130	2.644

NOTES:

1. For payment purposes, a new enrollee is a beneficiary who did not have 12 months of Part B eligibility in the data collection year. The CMS-HCC new enrollee model is not based on diagnosis, but includes factors for different age and gender combinations by Medicaid and the original reason for Medicare entitlement.
2. The relative risk scores in this table were calculated by dividing the parameter estimates by the Part C national average predicted expenditures (CMS Part C Denominator). The Part C Denominator value used is $8,034.71.

SOURCE: RTI International analysis of 2006/2007 Medicare 5% sample.

Table 11. List of Disease Hierarchies for the Revised CMS-HCC Model

DISEASE HIERARCHIES

Hierarchical Condition Category (HCC)	If the Disease Group is Listed in this column…	…Then drop the HCC(s) listed in this column
	Hierarchical Condition Category (HCC) LABEL	
8	Metastatic Cancer and Acute Leukemia	9,10,11,12
9	Lung and Other Severe Cancers	10,11,12
10	Lymphoma and Other Cancers	11,12
11	Colorectal, Bladder, and Other Cancers	12
17	Diabetes with Acute Complications	18,19
18	Diabetes with Chronic Complications	19
27	End-Stage Liver Disease	28,29,80
28	Cirrhosis of Liver	29
46	Severe Hematological Disorders	48
51	Dementia With Complications	52
54	Drug/Alcohol Psychosis	55
57	Schizophrenia	58
70	Quadriplegia	71,72,103,104,169
71	Paraplegia	72,104,169
72	Spinal Cord Disorders/Injuries	169
82	Respirator Dependence/Tracheostomy Status	83,84
83	Respiratory Arrest	84
86	Acute Myocardial Infarction	87,88
87	Unstable Angina and Other Acute Ischemic Heart Disease	88
99	Cerebral Hemorrhage	100
103	Hemiplegia/Hemiparesis	104
106	Atherosclerosis of the Extremities with Ulceration or Gangrene	107,108,161,189
107	Vascular Disease with Complications	108
110	Cystic Fibrosis	111,112
111	Chronic Obstructive Pulmonary Disease	112
114	Aspiration and Specified Bacterial Pneumonias	115
134	Dialysis Status	135,136,137,138,139,140,141
135	Acute Renal Failure	136,137,138,139,140,141
136	Chronic Kidney Disease, Stage 5	137,138,139,140,141
137	Chronic Kidney Disease, Severe (Stage 4)	138,139,140,141
138	Chronic Kidney Disease, Moderate (Stage 3)	139,140,141
139	Chronic Kidney Disease, Mild or Unspecified (Stages 1-2 or Unspecified)	140,141
140	Unspecified Renal Failure	141
157	Pressure Ulcer of Skin with Necrosis Through to Muscle, Tendon, or Bone	158,159,160,161
158	Pressure Ulcer of Skin with Full Thickness Skin Loss	159,160,161
159	Pressure Ulcer of Skin with Partial Thickness Skin Loss	160,161
160	Pressure Pre-Ulcer Skin Changes or Unspecified Stage	161
166	Severe Head Injury	80,167

How Payments are Made with a Disease Hierarchy EXAMPLE: If a beneficiary triggers HCCs 140 (Unspecified Renal Failure) and 141 (Nephritis), then HCC 141 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 organization's payment will be based on HCC 140 rather than HCC 141.

Table 12. Comparison of Current and Revised CMS-HCC Risk Adjustment Model HCCs

Current Model			Revised Model	
HCC	**Description**	**Category Short Name**	**HCC**	**Description**
HCC1	HIV/AIDS	Infection	HCC1	HIV/AIDS
HCC2	Septicemia/Shock		*HCC2*	*Septicemia, Sepsis, Systemic Inflammatory Response Syndrome/Shock*
HCC5	Opportunistic Infections		HCC6	Opportunistic Infections
HCC7	Metastatic Cancer and Acute Leukemia	Neoplasm	HCC8	Metastatic Cancer and Acute Leukemia
HCC8	Lung, Upper Digestive Tract, and Other Severe Cancers		HCC9	Lung and Other Severe Cancers
HCC9	Lymphatic, Head and Neck, Brain, and Other Major Cancers		HCC10	Lymphoma and Other Cancers
HCC10	Breast, Prostate, Colorectal and Other Cancers and Tumors		**HCC11**	**Colorectal, Bladder, and Other Cancers**
			HCC12	Breast, Prostate, and Other Cancers and Tumors
HCC15	Diabetes with Renal or Peripheral Circulatory Manifestation	Diabetes	HCC17	Diabetes with Acute Complications
HCC16	Diabetes with Neurologic or Other Specified Manifestation		*HCC18*	*Diabetes with Chronic Complications*
HCC17	Diabetes with Acute Complications		HCC19	Diabetes without Complication
HCC18	Diabetes with Ophthalmologic or Unspecified Manifestation			
HCC19	Diabetes without Complication			
HCC21	Protein-Calorie Malnutrition	Metabolic	HCC21	Protein-Calorie Malnutrition
			HCC22	**Morbid Obesity**
			HCC23	**Other Significant Endocrine and Metabolic Disorders**
HCC25	End-Stage Liver Disease	Liver	HCC27	End-Stage Liver Disease
HCC26	Cirrhosis of Liver		HCC28	Cirrhosis of Liver
HCC27	Chronic Hepatitis		HCC29	Chronic Hepatitis
HCC31	Intestinal Obstruction/Perforation	Gastrointestinal	HCC33	Intestinal Obstruction/Perforation
HCC32	Pancreatic Disease		*HCC34*	*Chronic Pancreatitis*
HCC33	Inflammatory Bowel Disease		HCC35	Inflammatory Bowel Disease
HCC37	Bone/Joint/Muscle Infections/Necrosis	Musculoskeletal	HCC39	Bone/Joint/Muscle Infections/Necrosis
HCC38	Rheumatoid Arthritis and Inflammatory Connective Tissue Disease		HCC40	Rheumatoid Arthritis and Inflammatory Connective Tissue Disease
HCC44	Severe Hematological Disorders	Blood	HCC46	Severe Hematological Disorders
HCC45	Disorders of Immunity		HCC47	Disorders of Immunity
			HCC48	**Coagulation Defects and Other Specified Hematological Disorders**
		Cognitive	**HCC51**	**Dementia With Complications**
			HCC52	**Dementia Without Complication**
HCC51	Drug/Alcohol Psychosis	Substance Abuse	HCC54	Drug/Alcohol Psychosis
HCC52	Drug/Alcohol Dependence		HCC55	Drug/Alcohol Dependence

Current Model			Revised Model	
HCC	**Description**	**Category Short Name**	**HCC**	**Description**
HCC54	Schizophrenia	Psychiatric	HCC57	Schizophrenia
HCC55	Major Depressive, Bipolar, and Paranoid Disorders		HCC58	Major Depressive, Bipolar, and Paranoid Disorders
HCC67	Quadriplegia, Other Extensive Paralysis	Spinal	*HCC70*	*Quadriplegia*
HCC68	Paraplegia		HCC71	Paraplegia
HCC69	Spinal Cord Disorders/Injuries		HCC72	Spinal Cord Disorders/Injuries
HCC70	Muscular Dystrophy	Neurological	**HCC73**	**Amyotrophic Lateral Sclerosis and Other Motor Neuron Disease**
HCC71	Polyneuropathy		**HCC74**	**Cerebral Palsy**
HCC72	Multiple Sclerosis		HCC75	Polyneuropathy
HCC73	Parkinson's and Huntington's Diseases		HCC76	Muscular Dystrophy
HCC74	Seizure Disorders and Convulsions		HCC77	Multiple Sclerosis
HCC75	Coma, Brain Compression/Anoxic Damage		HCC78	Parkinson's and Huntington's Diseases
			HCC79	Seizure Disorders and Convulsions
			HCC80	Coma, Brain Compression/Anoxic Damage
HCC77	Respirator Dependence/Tracheostomy Status	Arrest	HCC82	Respirator Dependence/Tracheostomy Status
HCC78	Respiratory Arrest		HCC83	Respiratory Arrest
HCC79	Cardio-Respiratory Failure and Shock		HCC84	Cardio-Respiratory Failure and Shock
HCC80	Congestive Heart Failure	Heart	HCC85	Congestive Heart Failure
HCC81	Acute Myocardial Infarction		HCC86	Acute Myocardial Infarction
HCC82	Unstable Angina and Other Acute Ischemic Heart Disease		HCC87	Unstable Angina and Other Acute Ischemic Heart Disease
HCC83	Angina Pectoris/Old Myocardial Infraction		*HCC88*	*Angina Pectoris*
HCC92	Specified Heart Arrhythmias		HCC96	Specified Heart Arrhythmias
HCC95	Cerebral Hemorrhage	Cerebrovascular Disease	HCC99	Cerebral Hemorrhage
HCC96	Ischemic or Unspecified Stroke		HCC100	Ischemic or Unspecified Stroke
HCC100	Hemiplegia/Hemiparesis		HCC103	Hemiplegia/Hemiparesis
HCC101	Cerebral Palsy and Other Paralytic Syndromes		*HCC104*	*Monoplegia, Other Paralytic Syndromes*
HCC104	Vascular Disease with Complications	Vascular	**HCC106**	**Atherosclerosis of the Extremities with Ulceration or Gangrene**
HCC105	Vascular Disease		HCC107	Vascular Disease with Complications
			HCC108	Vascular Disease
HCC107	Cystic Fibrosis	Lung	HCC110	Cystic Fibrosis
HCC108	Chronic Obstructive Pulmonary Disease		HCC111	Chronic Obstructive Pulmonary Disease
HCC111	Aspiration and Specified Bacterial Pneumonias		**HCC112**	**Fibrosis of Lung and Other Chronic Lung Disorders**
HCC112	Pneumococcal Pneumonia, Empyema, Lung Abscess		HCC114	Aspiration and Specified Bacterial Pneumonias
			HCC115	Pneumococcal Pneumonia, Empyema, Lung Abscess
HCC119	Proliferative Diabetic Retinopathy and Vitreous Hemorrhage	Eye	HCC122	Proliferative Diabetic Retinopathy and Vitreous Hemorrhage
			HCC124	**Exudative Macular Degeneration**
HCC130	Dialysis Status	Kidney	HCC134	Dialysis Status

Current Model			Revised Model	
HCC	**Description**	**Category Short Name**	**HCC**	**Description**
HCC131	Renal Failure		*HCC135*	*Acute Renal Failure*
HCC132	Nephritis		*HCC136*	*Chronic Kidney Disease, Stage 5*
			HCC137	*Chronic Kidney Disease, Severe (Stage 4)*
			HCC138	*Chronic Kidney Disease, Moderate (Stage 3)*
			HCC139	*Chronic Kidney Disease, Mild or Unspecified (Stages 1-2 or Unspecified)*
			HCC140	*Unspecified Renal Failure*
			HCC141	Nephritis
HCC148	Decubitus Ulcer of Skin	Skin	**HCC157**	**Pressure Ulcer of Skin with Necrosis Through to Muscle, Tendon, or Bone**
HCC149	Chronic Ulcer of Skin, Except Decubitus		**HCC158**	**Pressure Ulcer of Skin with Full Thickness Skin Loss**
HCC150	Extensive Third-Degree Burns		**HCC159**	**Pressure Ulcer of Skin with Partial Thickness Skin Loss**
			HCC160	Pressure Pre-Ulcer Skin Changes or Unspecified Stage
			HCC161	Chronic Ulcer of Skin, Except Pressure
			HCC162	*Severe Skin Burn or Condition*
HCC154	Severe Head Injury	Injury	HCC166	Severe Head Injury
HCC155	Major Head Injury		HCC167	Major Head Injury
HCC157	Vertebral Fractures w/o Spinal Cord Injury		HCC169	Vertebral Fractures without Spinal Cord Injury
HCC158	Hip Fracture/Dislocation		HCC170	Hip Fracture/Dislocation
HCC161	Traumatic Amputation		*HCC173*	*Traumatic Amputations and Complications*
HCC164	Major Complications of Medical Care and Trauma	Complications	*HCC176*	*Complications of Specified Implanted Device or Graft*
HCC174	Major Organ Transplant Status	Transplant	HCC186	Major Organ Transplant or Replacement Status
HCC176	Artificial Openings for Feeding or Elimination	Openings	HCC188	Artificial Openings for Feeding or Elimination
HCC177	Amputation Status, Lower Limb/Amputation Complications	Amputation	HCC189	Amputation Status, Lower Limb/Amputation Complications
		Disabled/Disease Interactions		
D-HCC5	Disabled_Opportunistic Infections		D_HCC6	Disabled, Opportunistic Infections
D-HCC44	Disabled_Severe Hematological Disorders		**D_HCC34**	**Disabled, Chronic Pancreatitis**
D-HCC51	Disabled_Drug/Alcohol Psychosis		D_HCC46	Disabled, Severe Hematological Disorders
D-HCC52	Disabled_Drug/Alcohol Dependence		D_HCC54	Disabled, Drug/Alcohol Psychosis
D-HCC107	Disabled_Cystic Fibrosis		D_HCC55	Disabled, Drug/Alcohol Dependence
			D_HCC110	Disabled, Cystic Fibrosis
			D_HCC176	**Disabled, Complications of Specified Implanted Device or Graft**
		DiseaseInteractions		
INT1	DM_CHF		**SEPSIS CARD RESP FAIL**	**Sepsis*Cardiorespiratory Failure**
INT2	DM_CVD		**CANCER IMMUNE**	**Cancer*Immune Disorders**
INT3	CHF COPD		DIABETES CHF	Diabetes*Congestive Heart Failure

Current Model			Revised Model	
HCC	**Description**	**Category Short Name**	**HCC**	**Description**
INT4	COPD CVD CAD		CHF COPD	Congestive Heart Failure*Chronic Obstructive Pulmonary Disease
INT5	RF CHF		CHF RENAL	Congestive Heart Failure*Renal Disease
INT6	RF CHF DM		**COPD CARD RESP FAIL**	**Chronic Obstructive Pulmonary Disease*Cardiorespiratory Failure**

Current Model NOTES:

Beneficiaries with three-way interaction RF_CHF_DM are excluded from the two-way interactions DM_CHF and RF_CHF.
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, 100-101).
CAD is coronary artery disease (HCCs 81-83).
RF is renal failure (HCC 131).

Revised Model NOTES:

New HCCs, demographic factors, or interactions (compared to the current model HCCs) are bolded.
Substantially revised HCCs, demographic factors, or interactions (compared to the current model HCCs) are in italics.
In the "disease interactions", the variables are defined as follows:
Sepsis = HCC 2.
Cardiorespiratory Failure = HCCs 82-84.
Cancer = HCCs 8-12.
Immune Disorders = HCC 47.
Diabetes = HCCs 17, 18, 19.
Congestive Heart Failure = HCC 85.
Chronic Obstructive Pulmonary Disease = HCCs 110-111.
Renal Disease = HCCs 134-141.

Table 13. PACE and FIDE-SNP Frailty Factors

ADL	FIDE-SNP Factors (Non-Medicaid)	PACE Recalibrated Factors (Non-Medicaid)	FIDE-SNP Factors (Medicaid)	PACE Recalibrated Factors (Medicaid)
0	-0.093	-0.079	-0.180	-0.201
1-2	0.112	0.118	0.035	0.000
3-4	0.201	0.187	0.155	0.105
5-6	0.381	0.335	0.200	0.121

Table 14. RxHCC Model Relative Factors for Continuing Enrollees

		Continuing Enrollee (CE) RxHCC Model Segments				
Variable	**Disease Group**	Community, Non-Low Income, Age>=65	Community, Non-Low Income, Age<65	Community, Low Income, Age>=65	Community, Low Income, Age<65	Institutional
Female						
0-34 Years		-	0.260	-	0.397	1.525
35-44 Years		-	0.471	-	0.587	1.546
45-54 Years		-	0.579	-	0.659	1.461
55-59 Years		-	0.568	-	0.630	1.384
60-64 Years		-	0.570	-	0.606	1.331
65 Years		0.410	-	0.440	-	1.422
66 Years		0.410	-	0.440	-	1.422
67 Years		0.410	-	0.440	-	1.422
68 Years		0.410	-	0.440	-	1.422
69 Years		0.410	-	0.440	-	1.422
70-74 Years		0.406	-	0.430	-	1.343
75-79 Years		0.413	-	0.428	-	1.287
80-84 Years		0.423	-	0.423	-	1.234
85-89 Years		0.432	-	0.414	-	1.181
90-94 Years		0.430	-	0.391	-	1.110
95 Years or Over		0.405	-	0.322	-	0.965
Male						
0-34 Years		-	0.240	-	0.426	1.552
35-44 Years		-	0.395	-	0.552	1.512
45-54 Years		-	0.522	-	0.592	1.443
55-59 Years		-	0.517	-	0.560	1.350
60-64 Years		-	0.531	-	0.531	1.299
65 Years		0.416	-	0.360	-	1.360
66 Years		0.416	-	0.360	-	1.360
67 Years		0.416	-	0.360	-	1.360
68 Years		0.416	-	0.360	-	1.360
69 Years		0.416	-	0.360	-	1.360
70-74 Years		0.407	-	0.352	-	1.316
75-79 Years		0.398	-	0.347	-	1.274
80-84 Years		0.392	-	0.336	-	1.246
85-89 Years		0.394	-	0.336	-	1.225
90-94 Years		0.419	-	0.357	-	1.182
95 Years or Over		0.423	-	0.350	-	1.079
Originally Disabled Interactions with Sex						
Originally Disabled		-	-	-	-	0.027
Originally Disabled_Female		0.070	-	0.100	-	-
Originally Disabled_Female_Age 65		-	-	-	-	-

Variable	Disease Group	Community, Non-Low Income, Age>=65	Community, Non-Low Income, Age<65	Community, Low Income, Age>=65	Community, Low Income, Age<65	Institutional
Originally Disabled_Female_Age 66-69		-	-	-	-	-
Originally Disabled_Female_Age 70-74		-	-	-	-	-
Originally Disabled_Female_Age 75+		-	-	-	-	-
Originally Disabled_Male		0.021	-	0.089	-	-
Originally Disabled_Male_Age 65		-	-	-	-	-
Originally Disabled_Male_Age 66-69		-	-	-	-	-
Originally Disabled_Male_Age 70-74		-	-	-	-	-
Originally Disabled_Male_Age 75+		-	-	-	-	-

Disease Coefficients	Description Label	Community, Non-Low Income, Age>=65	Community, Non-Low Income, Age<65	Community, Low Income, Age>=65	Community, Low Income, Age<65	Institutional
RXHCC1	HIV/AIDS	1.599	2.337	2.082	2.496	1.058
RXHCC5	Opportunistic Infections	0.118	0.130	0.082	0.176	0.083
RXHCC8	Chronic Myeloid Leukemia	1.651	2.073	2.059	2.329	1.037
RXHCC9	Multiple Myeloma and Other Neoplastic Disorders	1.095	1.278	0.997	1.192	0.546
RXHCC10	Breast, Lung, and Other Cancers and Tumors	0.206	0.209	0.233	0.249	0.101
RXHCC11	Prostate and Other Cancers and Tumors	0.039	0.052	0.114	0.062	0.082
RXHCC14	Diabetes with Complications	0.251	0.188	0.270	0.266	0.154
RXHCC15	Diabetes without Complication	0.175	0.152	0.209	0.218	0.110
RXHCC18	Diabetes Insipidus and Other Endocrine and Metabolic Disorders	0.247	0.577	0.183	0.612	0.124
RXHCC19	Pituitary, Adrenal Gland, and Other Endocrine and Metabolic Disorders	0.045	0.065	0.029	0.059	0.061
RXHCC20	Thyroid Disorders	0.038	0.095	0.045	0.102	0.037
RXHCC21	Morbid Obesity	0.042	0.016	0.037	0.048	0.067
RXHCC23	Disorders of Lipoid Metabolism	0.119	0.131	0.139	0.178	0.063
RXHCC25	Chronic Viral Hepatitis	0.077	0.041	0.216	0.109	—
RXHCC30	Chronic Pancreatitis	0.091	0.174	0.045	0.074	0.021
RXHCC31	Pancreatic Disorders and Intestinal Malabsorption, Except Pancreatitis	0.034	0.075	0.034	0.074	0.021
RXHCC32	Inflammatory Bowel Disease	0.268	0.257	0.186	0.309	0.075
RXHCC33	Esophageal Reflux and Other Disorders of Esophagus	0.136	0.114	0.158	0.172	0.074
RXHCC38	Aseptic Necrosis of Bone	0.056	0.166	0.043	0.229	0.068
RXHCC40	Psoriatic Arthropathy	0.321	0.449	0.560	0.992	0.374
RXHCC41	Rheumatoid Arthritis and Other Inflammatory Polyarthropathy	0.172	0.264	0.193	0.383	0.095
RXHCC42	Systemic Lupus Erythematosus, Other Connective Tissue Disorders, and Inflammatory Spondylopathies	0.125	0.249	0.158	0.261	0.086
RXHCC45	Osteoporosis, Vertebral and Pathological Fractures	0.093	0.162	0.123	0.178	0.028
RXHCC47	Sickle Cell Anemia	0.140	0.089	0.131	0.425	0.035
RXHCC48	Myelodysplastic Syndromes, Except High-Grade	0.209	0.371	0.293	0.226	0.420
RXHCC49	Immune Disorders	0.151	0.255	0.128	0.271	0.142
RXHCC50	Aplastic Anemia and Other Significant Blood Disorders	0.045	0.089	0.058	0.072	0.035
RXHCC54	Alzheimer`s Disease	0.471	0.264	0.304	0.181	0.015
RXHCC55	Dementia, Except Alzheimer`s Disease	0.253	0.098	0.141	0.048	—
RXHCC58	Schizophrenia	0.433	0.574	0.633	0.940	0.334
RXHCC59	Bipolar Disorders	0.364	0.442	0.419	0.664	0.287
RXHCC60	Major Depression	0.274	0.350	0.302	0.430	0.202
RXHCC61	Specified Anxiety, Personality, and Behavior Disorders	0.163	0.224	0.215	0.430	0.172
RXHCC62	Depression	0.139	0.177	0.143	0.226	0.115
RXHCC63	Anxiety Disorders	0.057	0.127	0.086	0.179	0.115
RXHCC65	Autism	0.180	0.325	0.486	0.648	0.172

Disease Coefficients	Description Label	Community, Non-Low Income, Age>=65	Community, Non-Low Income, Age<65	Community, Low Income, Age>=65	Community, Low Income, Age<65	Institutional
RXHCC66	Profound or Severe Mental Retardation/Developmental Disability	0.028	0.325	0.486	0.393	—
RXHCC67	Moderate Mental Retardation/Developmental Disability	0.028	0.173	0.396	0.288	—
RXHCC68	Mild or Unspecified Mental Retardation/Developmental Disability	0.011	0.051	0.234	0.141	—
RXHCC71	Myasthenia Gravis, Amyotrophic Lateral Sclerosis and Other Motor Neuron Disease	0.185	0.306	0.156	0.308	0.059
RXHCC72	Spinal Cord Disorders	0.064	0.170	0.071	0.094	—
RXHCC74	Polyneuropathy	0.089	0.215	0.081	0.179	0.059
RXHCC75	Multiple Sclerosis	0.448	0.796	0.485	1.313	0.121
RXHCC76	Parkinson`s Disease	0.420	0.501	0.290	0.286	0.154
RXHCC78	Intractable Epilepsy	0.364	0.640	0.347	0.897	0.123
RXHCC79	Epilepsy and Other Seizure Disorders, Except Intractable Epilepsy	0.221	0.269	0.166	0.363	0.077
RXHCC80	Convulsions	0.110	0.129	0.097	0.225	0.039
RXHCC81	Migraine Headaches	0.115	0.229	0.109	0.197	0.144
RXHCC83	Trigeminal and Postherpetic Neuralgia	0.095	0.179	0.105	0.151	0.081
RXHCC86	Pulmonary Hypertension and Other Pulmonary Heart Disease	0.253	0.395	0.286	0.338	0.122
RXHCC87	Congestive Heart Failure	0.177	0.091	0.242	0.106	0.098
RXHCC88	Hypertension	0.168	0.077	0.215	0.094	0.063
RXHCC89	Coronary Artery Disease	0.146	0.083	0.130	0.045	0.017
RXHCC93	Atrial Arrhythmias	0.062	0.046	0.022	—	0.013
RXHCC97	Cerebrovascular Disease, Except Hemorrhage or Aneurysm	0.065	—	0.049	—	—
RXHCC98	Spastic Hemiplegia	0.146	0.241	0.055	0.146	0.013
RXHCC100	Venous Thromboembolism	0.014	0.048	—	0.083	—
RXHCC101	Peripheral Vascular Disease	0.057	0.030	0.091	0.063	—
RXHCC103	Cystic Fibrosis	0.199	0.692	0.219	1.320	0.114
RXHCC104	Chronic Obstructive Pulmonary Disease and Asthma	0.199	0.125	0.217	0.200	0.114
RXHCC105	Pulmonary Fibrosis and Other Chronic Lung Disorders	0.113	0.125	0.096	0.199	0.038
RXHCC106	Gram-Negative/Staphylococcus Pneumonia and Other Lung Infections	—	0.079	—	0.042	0.027
RXHCC111	Diabetic Retinopathy	0.094	0.082	0.078	0.038	0.034
RXHCC113	Open-Angle Glaucoma	0.142	0.101	0.152	0.122	0.100
RXHCC120	Kidney Transplant Status	0.275	0.165	0.379	0.399	0.329
RXHCC121	Dialysis Status	0.220	0.295	0.278	0.526	0.211
RXHCC122	Chronic Kidney Disease Stage 5	0.118	0.138	0.128	0.164	0.108
RXHCC123	Chronic Kidney Disease Stage 4	0.118	0.138	0.128	0.164	0.108
RXHCC124	Chronic Kidney Disease Stage 3	0.100	0.138	0.113	0.164	0.080
RXHCC125	Chronic Kidney Disease Stage 1, 2, or Unspecified	0.040	0.059	0.035	0.070	0.041
RXHCC126	Nephritis	0.040	0.034	0.035	0.068	0.013
RXHCC142	Chronic Ulcer of Skin, Except Pressure	0.042	0.060	0.027	0.060	—
RXHCC145	Pemphigus	0.111	0.146	0.120	0.254	—
RXHCC147	Psoriasis, Except with Arthropathy	0.106	0.186	0.202	0.284	0.124
RXHCC156	Narcolepsy and Cataplexy	0.274	0.344	0.161	0.432	0.102
RXHCC166	Lung Transplant Status	0.948	0.912	0.949	1.093	0.696
RXHCC167	Major Organ Transplant Status, Except Lung, Kidney, and Pancreas	0.415	0.378	0.409	0.471	0.329
RXHCC168	Pancreas Transplant Status	0.275	0.165	0.379	0.345	0.329
Non-Aged Disease Interactions						
NonAged_RXHCC1	HIV/AIDS	-	-	-	-	1.074
NonAged_RXHCC58	Schizophrenia	-	-	-	-	0.382
NonAged_RXHCC59	Bipolar Disorders	-	-	-	-	0.238
NonAged_RXHCC60	Major Depression	-	-	-	-	0.112
NonAged_RXHCC61	Specified Anxiety, Personality, and Behavior Disorders	-	-	-	-	0.112
NonAged_RXHCC62	Depression	-	-	-	-	0.056
NonAged_RXHCC63	Anxiety Disorders	-	-	-	-	0.032

Disease Coefficients	Description Label	Community, Non-Low Income, Age>=65	Community, Non-Low Income, Age<65	Community, Low Income, Age>=65	Community, Low Income, Age<65	Institutional
NonAged_RXHCC65	Autism	-	-	-	-	0.112
NonAged_RXHCC75	Multiple Sclerosis	-	-	-	-	0.467
NonAged_RXHCC78	Intractable Epilepsy	-	-	-	-	0.199
NonAged_RXHCC79	Epilepsy and Other Seizure Disorders, Except Intractable Epilepsy	-	-	-	-	0.040
NonAged_RXHCC80	Convulsions	-	-	-	-	0.034

Note:
The relative risk scores in this table were calculated by dividing the parameter estimates by the Part D national average predicted expenditures (CMS Part D Denominator). The Part D Denominator value used was $1,107.82. This Part D Denominator is based on the combined PDP and MA-PD populations, and it includes adjustments for new model diagnoses not yet submitted by the MA-PD population.

Source: RTI Analysis of 100% 2008 PDE, 2007 NCH, 2008 HPMS, 2008 CME, and 2007-2008 Denominator.

Table 15. RxHCC Model Relative Factors for New Enrollees, Non-Low Income

Variable	Baseline – Not Concurrently ESRD, Not Originally Disabled	Concurrently ESRD, Not Originally Disabled	Originally Disabled, Not Concurrently ESRD	Originally Disabled, Concurrently ESRD
Female				
0-34 Years	0.476	0.908	-	-
35-44 Years	0.793	1.225	-	-
45-54 Years	1.061	1.493	-	-
55-59 Years	1.124	1.556	-	-
60-64 Years	1.170	1.601	-	-
65 Years	0.755	1.187	1.151	1.583
66 Years	0.751	1.183	0.899	1.330
67 Years	0.751	1.183	0.899	1.330
68 Years	0.751	1.183	0.899	1.330
69 Years	0.751	1.183	0.899	1.330
70-74 Years	0.737	1.168	0.737	1.168
75-79 Years	0.674	1.106	0.674	1.106
80-84 Years	0.646	1.078	0.646	1.078
85-89 Years	0.566	0.997	0.566	0.997
90-94 Years	0.566	0.997	0.566	0.997
95 Years or Over	0.566	0.997	0.566	0.997
Male				
0-34 Years	0.322	0.754	-	-
35-44 Years	0.608	1.040	-	-
45-54 Years	0.874	1.306	-	-
55-59 Years	0.926	1.358	-	-
60-64 Years	1.013	1.445	-	-
65 Years	0.771	1.203	1.020	1.451
66 Years	0.757	1.188	0.757	1.188
67 Years	0.757	1.188	0.757	1.188
68 Years	0.757	1.188	0.757	1.188
69 Years	0.757	1.188	0.757	1.188
70-74 Years	0.719	1.151	0.719	1.151
75-79 Years	0.638	1.070	0.638	1.070
80-84 Years	0.540	0.972	0.540	0.972
85-89 Years	0.462	0.894	0.462	0.894
90-94 Years	0.462	0.894	0.462	0.894
95 Years or Over	0.462	0.894	0.462	0.894

NOTES:

1. The Part D Denominator used to calculate relative factors is $1,107.82. This Part D Denominator is based on the combined PDP and MA-PD populations. MA-PD risk scores were adjusted to account for new model diagnoses not yet submitted for the MA-PD population.

2. Originally Disabled is defined as originally entitled to Medicare by disability only (OREC = 1).

3. Concurrently ESRD is defined as at least one month of ESRD status—dialysis (D), transplant (1, 2, 5, 6 or N), or post-graft (G, R or Y) in the payment year (2008 in the model calibration).

Source: RTI Analysis of 100% 2008 PDE SAF, 2007-2008 HPMS, 2008 CME, and 2007-2008 Denominator.

Table 16. RxHCC Model Relative Factors for New Enrollees, Low Income

Variable	Baseline – Not Concurrently ESRD and Not Originally Disabled	Concurrently ESRD, Not Originally Disabled	Originally Disabled, Not Concurrently ESRD	Originally Disabled, Concurrently ESRD
Female				
0-34 Years	0.875	1.413	-	-
35-44 Years	1.217	1.755	-	-
45-54 Years	1.253	1.792	-	-
55-59 Years	1.142	1.681	-	-
60-64 Years	1.116	1.654	-	-
65 Years	0.851	1.390	1.040	1.579
66 Years	0.587	1.126	0.742	1.280
67 Years	0.587	1.126	0.742	1.280
68 Years	0.587	1.126	0.742	1.280
69 Years	0.587	1.126	0.742	1.280
70-74 Years	0.598	1.137	0.753	1.291
75-79 Years	0.652	1.191	0.807	1.345
80-84 Years	0.684	1.222	0.839	1.377
85-89 Years	0.683	1.221	0.837	1.376
90-94 Years	0.683	1.221	0.837	1.376
95 Years or Over	0.683	1.221	0.837	1.376
Male				
0-34 Years	0.820	1.358	-	-
35-44 Years	1.093	1.632	-	-
45-54 Years	1.054	1.592	-	-
55-59 Years	0.914	1.452	-	-
60-64 Years	0.866	1.404	-	-
65 Years	0.674	1.212	0.772	1.311
66 Years	0.437	0.975	0.538	1.077
67 Years	0.437	0.975	0.538	1.077
68 Years	0.437	0.975	0.538	1.077
69 Years	0.437	0.975	0.538	1.077
70-74 Years	0.449	0.987	0.550	1.089
75-79 Years	0.477	1.016	0.477	1.016
80-84 Years	0.470	1.009	0.470	1.009
85-89 Years	0.507	1.045	0.507	1.045
90-94 Years	0.507	1.045	0.507	1.045
95 Years or Over	0.507	1.045	0.507	1.045

NOTES:

1. The Part D Denominator used to calculate relative factors is $1,107.82. This Part D Denominator is based on the combined PDP and MA-PD populations. MA-PD risk scores were adjusted to account for new model diagnoses not yet submitted for the MA-PD population.

2. Originally Disabled is defined as originally entitled to Medicare by disability only (OREC = 1).

3. Concurrently ESRD is defined as at least one month of ESRD status—dialysis (D), transplant (1, 2, 5, 6 or N), or post-graft (G, R or Y) in the payment year (2008 in the model calibration).

Source: RTI Analysis of 100% 2008 PDE SAF, 2007-2008 HPMS, 2008 CME, and 2007-2008 Denominator.

Table 17. RxHCC Model Relative Factors for New Enrollees, Institutional

Variable	Baseline – Not Concurrently ESRD	Concurrently ESRD
Female		
0-34 Years	2.095	2.326
35-44 Years	2.095	2.326
45-54 Years	2.012	2.243
55-59 Years	1.975	2.205
60-64 Years	1.917	2.148
65 Years	1.988	2.218
66 Years	1.783	2.013
67 Years	1.783	2.013
68 Years	1.783	2.013
69 Years	1.783	2.013
70-74 Years	1.616	1.846
75-79 Years	1.551	1.781
80-84 Years	1.378	1.609
85-89 Years	1.214	1.445
90-94 Years	1.214	1.445
95 Years or Over	1.214	1.445
Male		
0-34 Years	2.118	2.348
35-44 Years	2.118	2.348
45-54 Years	2.059	2.289
55-59 Years	1.938	2.169
60-64 Years	1.792	2.023
65 Years	1.790	2.020
66 Years	1.683	1.914
67 Years	1.683	1.914
68 Years	1.683	1.914
69 Years	1.683	1.914
70-74 Years	1.573	1.804
75-79 Years	1.539	1.769
80-84 Years	1.505	1.736
85-89 Years	1.293	1.523
90-94 Years	1.293	1.523
95 Years or Over	1.293	1.523

NOTES:

1. The Part D Denominator used to calculate relative factors is $1,107.82. This Part D Denominator is based on the combined PDP and MA-PD populations. MA-PD risk scores were adjusted to account for new model diagnoses not yet submitted for the MA-PD population.

2. Concurrently ESRD is defined as at least one month of ESRD status—dialysis (D), transplant (1, 2, 5, 6 or N), or post-graft (G, R or Y) in the payment year (2008 in the model calibration).3. The Part D New Enrollee Institutional sample does not have an Originally Disabled add-on (set to $0 because of regression results).

Source: RTI Analysis of 100% 2008 PDE SAF, 2007-2008 HPMS, 2008 CME, and 2007-2008 Denominator.

Table 18. List of Disease Hierarchies for the Revised RxHCC Model

DISEASE HIERARCHIES

Rx Hierarchical Condition Category (RxHCC)	If the Disease Group is Listed in this column…	…Then drop the RxHCC(s) listed in this column
	Rx Hierarchical Condition Category (RxHCC) LABEL	
8	Chronic Myeloid Leukemia	9,10,11,48,50
9	Multiple Myeloma and Other Neoplastic Disorders	10,11,48,50
10	Breast, Lung, and Other Cancers and Tumors	11
14	Diabetes with Complications	15
18	Diabetes Insipidus and Other Endocrine and Metabolic Disorders	19
30	Chronic Pancreatitis	31
40	Psoriatic Arthropathy	41,42,147
41	Rheumatoid Arthritis and Other Inflammatory Polyarthropathy	42
47	Sickle Cell Anemia	50
48	Myelodysplastic Syndromes, Except High-Grade	50
54	Alzheimer's Disease	55
58	Schizophrenia	59,60,61,62,63,65,66,67,68
59	Bipolar Disorders	60,61,62,63
60	Major Depression	61,62,63
61	Specified Anxiety, Personality, and Behavior Disorders	62,63
62	Depression	63
65	Autism	61,62,63,66,67,68
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SOURCE: RTI International.

Attachment VII: 2012 Call Letter

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How to Use This Call Letter

The 2012 Call Letter contains information on the Part C and Part D programs. Also, we indicate when certain sections apply to cost-reimbursed HMOs, PACE programs, and employer and union-sponsored group health plans (EGWPs).

Over the past year, CMS has committed its resources to improving the quality of plan choices for beneficiaries who elect to enroll in Medicare Advantage and prescription drug plans. As part of this effort, CMS published a proposed regulation (4144-P) on November 22, 2010 that would make revisions to the Parts C and D regulations. CMS is currently reviewing comments submitted by the public and is in the process of developing the policies for the final rule. Since this year's final Call Letter will be released close to the expected final publication of the final rule (4144-F), the content is limited to clarification of current policy and operational guidance. However, requirements contained in the final rule may be included in this year's final Call Letter, even if they have not been included in this draft Call Letter. The Call Letter is divided into three sections: Program Updates, Improving Information Sharing & Transparency with Sponsors, and Improving Beneficiary Protections. These three sections contain information about Part C and Part D. We remind sponsoring organizations to continue to familiarize themselves with statutory requirements, regulations, and guidance governing the MA and Part D programs, including the Medicare Advantage and Prescription Drug Benefit Manuals. CMS will separately issue technical and procedural clarifications regarding bid and formulary submissions, benefits, HPMS data, CMS marketing models, and other operational issues of interest to sponsoring organizations.

Also note that this year some of the calendar items have dates that are earlier than for the 2011 contract year. This is as a result of the earlier Annual Enrollment Period (AEP) as compared to years past. Items with earlier due dates are indicated in the chart. Organizations and CMS need to work together to ensure contracting deadlines are met.

We hope this information helps you implement and comply with CMS policies and procedures as you prepare either to offer a plan for the first time or continue offering plans under the MA and/or Part D programs.

If you have questions concerning this Call Letter, please contact: Heather Rudo at Heather.Rudo@cms.hhs.gov (Part C issues) and Julie Gover at Julie.Gover2@cms.hhs.gov (Part D issues).

Section 1 – Program updates

This is a combined calendar listing of side-by-side key dates and timelines for operational activities that pertain to MA, MA-PD, PDP and cost-based plans. The calendar provides important operational dates for all organizations such as the date CMS bids are due, the date that organizations must inform CMS of their contract non-renewal, and dates for beneficiary mailings. The calendar has changed slightly from the draft version of the call letter to include updated timeframes based on external comments and to meet certain requirements of ACA.

2012 MA, MA-PD, Part D and Cost-Based Plan Calendar **(All dates, unless identified as statutory, are subject to change)**					
2011 ***Note: The dates listed under Part C include MA and MA-PD plans. The dates listed under Part D sponsors also apply to MA and cost-based plans offering a Part D benefit.**		***Part C**	***Part D sponsors**	**Cost**	**Date earlier than last year**
January 4, 2011	Release of the 2012 MAO/MAPD/PDP/SAE Applications in the Health Plan management System (HPMS)	✓	✓	✓	
January 5 & 12, 2011	Industry training on 2012 Applications	✓	✓	✓	
February 24, 2011	2012 Applications are due to CMS	✓	✓	✓	
March 2011	CMS releases guidance concerning updates to Parent Organization designations in HPMS	✓	✓	✓	✓
March 4, 2011	Initial Submission deadline for risk adjustment data with dates of service January 1, 2010 through December 31, 2010	✓		✓	
March 25, 2011	Release of the 2012 Formulary Submission Module in HPMS	✓	✓		
March 25 2011	Release of the 2012 Medication Therapy Management Module (MTMP) in HPMS		✓		
Early April 2011	CY 2012 OOPC estimates for each plan and an OOPC model will be made available to plan sponsors in SAS to download from the CMS website that will assist plans in meeting meaningful difference and total beneficiary cost requirements prior to bid submission.	✓	✓		

2012 MA, MA-PD, Part D and Cost-Based Plan Calendar **(All dates, unless identified as statutory, are subject to change)**					
2011 ***Note: The dates listed under Part C include MA and MA-PD plans. The dates listed under Part D sponsors also apply to MA and cost-based plans offering a Part D benefit.**		***Part C**	***Part D sponsors**	**Cost**	**Date earlier than last year**
Early April 2011	Release additional guidance regarding potentially duplicative plans, low enrollment plans and benefits review standards for 2012 bid submission.	✓	✓		
TBD	Conference call with industry to discuss the 2012 Call Letter.	✓	✓	✓	
April 4, 2011	2012 Final Call Letter released. Announce CY 2011 MA Capitation Rates and MA and Part D Payment Policies. *(applies to Part C and Part D sponsors only)*	✓	✓	✓	
April 4, 2011	2012 MTMP submission deadline		✓		
April 8, 2011	Release of the 2012 Plan Creation, Plan Benefit Package (PBP), and Bid Pricing Tool (BPT) Software of HPMS	✓	✓		
April 12 – 13, 2011	Medicare Advantage and Part D Spring Conference	✓	✓	✓	✓
April 15, 2011	Release of the 2012 PBP online Training Module	✓	✓		
April 15, 2011	Parent Organization Update requests from sponsors due to CMS (instructional memo to be released on March 25, 2011)	✓	✓	✓	✓
April 18, 2011	2012 Formulary Submissions due from all sponsors offering Part D (11:59 p.m. EDT) Transition Attestations due to CMS *(Part D sponsors only)*	✓	✓		
April/May 2011	CMS contacts MAOs with low enrollment plans	✓	✓	✓	
May 2011	Final ANOC/EOC, LIS rider, EOB, formularies, transition notice, provider directory, and pharmacy directory models for 2012 will be available for all organizations. (Models containing significant revisions will be released for public comment prior to this date).	✓	✓		

2012 MA, MA-PD, Part D and Cost-Based Plan Calendar **(All dates, unless identified as statutory, are subject to change)**					
2011 ***Note: The dates listed under Part C include MA and MA-PD plans. The dates listed under Part D sponsors also apply to MA and cost-based plans offering a Part D benefit.**		***Part C**	***Part D sponsors**	**Cost**	**Date earlier than last year**
May 2, 2011	*Voluntary non-renewal*: CMS strongly encourages MA, MA-PD and cost plans to notify us of an intention to non-renew a county or counties for individuals, but continue the county for "800 series" EGWP members, by May 2, 2011.	✓		✓	
May 2, 2011	*Voluntary non-renewal*: CMS strongly encourages Part D sponsors to notify us of any type of service area reduction, or conversion to offering employer-only contracts by May 2, 2011, so that we can make the required changes in HPMS to facilitate sponsors' ability to correctly upload their bids in June.		✓		
Early to Mid May 2011	Release Medicare Marketing Guidelines for CY 2012	✓	✓	✓	
Early to Mid May	Industry training on revised Medicare Marketing Guidelines and model documents	✓	✓	✓	
May 13, 2011	Release of the 2012 Bid Upload Functionality in HPMS	✓	✓	✓	
Late-May/June 2011	CMS sends eligibility determinations to applicants based on review of the 2012 applications for new contracts or service area expansions.	✓	✓	✓	
June 3, 2011	Release of the 2010 DIR Submission Module in HPMS		✓		
June 3, 2011	2012 MTMP Annual Review completed	✓	✓	✓	
June 3, 2011	Sponsors may begin to upload agent/broker compensation information into HPMS	✓	✓	✓	
June 6, 2011	Release of the 2012 Marketing Module in HPMS	✓	✓	✓	
June 6, 2011	Release of the 2012 Actuarial Certification Module in HPMS	✓	✓	✓	

2012 MA, MA-PD, Part D and Cost-Based Plan Calendar **(All dates, unless identified as statutory, are subject to change)**					
2011 ***Note: The dates listed under Part C include MA and MA-PD plans. The dates listed under Part D sponsors also apply to MA and cost-based plans offering a Part D benefit.**		***Part C**	***Part D sponsors**	**Cost**	**Date earlier than last year**
June 6, 2011	Deadline for submission of CY 2012 bids for all MA plans, MA-PD plans, PDPs, cost-based plans offering a Part D benefit, "800 series" EGWP and direct contract EGWP applicants and renewing organizations; deadline for cost-based plans wishing to appear in the 2011 Medicare Options Compare to submit PBPs (11:59 p.m. PDT). Voluntary Non-Renewal. Deadline for MA, MA-PD, PDPs and Cost-Based organizations to submit a contract non-renewal, service area reduction, or Plan Benefit Package (PBP) level non-renewal notice to CMS for CY 2012.	✓	✓	✓	
June to Early September, 2011	CMS completes review and approval of 2012 bid data. Submit attestations, contracts, and final actuarial certifications	✓	✓		
June 13, 2011	Deadline for submitting Supplemental Formulary files, Free First Fill file, Partial Gap file, Excluded Drug file, Over the Counter (OTC) drug file, and Home Infusion file through HPMS	✓	✓		
Late June, 2011	Release of the 2012 SB Hardcopy Change Request Module) on HPMS	✓	✓	✓	
Late June, 2011	Submission of HITECH identifying information for MA EPs and MA-affiliated hospitals and for attestation of qualifying MA organizations not offering MA HMO plans in HPMS	✓			
Late June, 2011	Final date to submit 2011 HITECH methodology for estimating portion of MA EP salary attributable to providing Part B services	✓			

2012 MA, MA-PD, Part D and Cost-Based Plan Calendar **(All dates, unless identified as statutory, are subject to change)**					
2011 ***Note: The dates listed under Part C include MA and MA-PD plans. The dates listed under Part D sponsors also apply to MA and cost-based plans offering a Part D benefit.**		***Part C**	***Part D sponsors**	**Cost**	**Date earlier than last year**
June 30, 2011	Final date to submit CY 2011 marketing materials to ensure timely CMS' review and approval. NOTE: Sponsors may continue to submit CY 2011 file and use materials as these may be filed in HPMS five calendar days prior to their use.	✓	✓	✓	
June 30, 2011	MAOs offering SNPs must provide their account managers with the total number of non-special needs individuals who continued to be enrolled as of January 1, 2011.	✓			
Late June 2011	Non-Renewal. CMS to issue an acknowledgement letter to all MA, MA-PD, PDP and Medicare cost-based plans that have notified CMS they are non-renewing or reducing their service area.	✓	✓	✓	
July1, 2011	Submission date for contracting MAOs (new and expanding) to provide CMS with a ratified contract with the State in order to operate a Medicaid dual eligible SNP for CY 2012.	✓			
July 5, 2011	Plans are expected to submit non-model Low Income Subsidy (LIS) riders to the regional office for review.		✓		
July 25, 2011	Submission deadline for agent/broker compensation information via HPMS upload.	✓	✓	✓	
July 29, 2011	CMS issues further details about MAO SNP disenrollment process for ineligible or "disproportionate share" SNP enrollees.	✓			

2012 MA, MA-PD, Part D and Cost-Based Plan Calendar **(All dates, unless identified as statutory, are subject to change)**					
2011 ***Note: The dates listed under Part C include MA and MA-PD plans. The dates listed under Part D sponsors also apply to MA and cost-based plans offering a Part D benefit.**		***Part C**	***Part D sponsors**	**Cost**	**Date earlier than last year**
Late July/Early August, 2011	Release of the 2012 Part D national average monthly bid amount, the Medicare Part D base beneficiary premium, the Part D regional low-income premium subsidy amounts, and the Medicare Advantage regional PPO benchmarks. Rebate reallocation period begins after release of the above amounts.	✓	✓	✓	✓
August 1, 2011	Plans are expected to submit model Low Income Subsidy (LIS) riders to the regional office for review.		✓		
Mid – August, 2011	CMS will release annual non-renewal guidance, including model final non-renewal beneficiary notification letters.				✓
August 25 – August 29, 2011	If applicable, plans preview the 2012 *Medicare & You* plan data in HPMS prior to printing of the CMS publication (not applicable to EGWPs).	✓	✓	✓	✓
Late August 2011	Contracting Materials submitted to CMS	✓	✓	✓	
End of August/Early September 2011	Plan preview period of star ratings in HPMS	✓	✓		
August 31 – September 2, 2011	First CY 2012 Medicare Plan Finder (MPF) Preview and (Out-of-Pocket Cost) OOPC Preview	✓	✓	✓	✓
September, 2011	CMS begins accepting plan correction requests upon contract approval.	✓	✓	✓	
September 2, 2011	Initial Submission deadline for risk adjustment data with dates of service from July 1, 2010 through June 30, 2011	✓		✓	
September 13 – September 16, 2011	Second CY 2012 Medicare Plan Finder (MPF) Preview and (Out-of-Pocket Cost) OOPC Preview	✓	✓	✓	✓

2012 MA, MA-PD, Part D and Cost-Based Plan Calendar **(All dates, unless identified as statutory, are subject to change)**					
2011 ***Note: The dates listed under Part C include MA and MA-PD plans. The dates listed under Part D sponsors also apply to MA and cost-based plans offering a Part D benefit.**		***Part C**	***Part D sponsors**	**Cost**	**Date earlier than last year**
Mid-September 2011	All 2012 contracts fully executed (signed by both parties: Part C/Part D sponsor and CMS)	✓	✓	✓	
Sept 15 – Sept 30, 2011	CMS mails the 2012 *Medicare & You* handbook to Medicare beneficiaries.	✓	✓	✓	✓
September 30, 2011	The beneficiary involuntary disenrollment notification must be a personalized letter and received by SNP enrollees who are no longer eligible for the SNP plan due to changes in service area, eligibility requirements or disproportionate share by September 30, 2011.	✓			

2012 MA, MA-PD, Part D and Cost-Based Plan Calendar **(All dates, unless identified as statutory, are subject to change)**					
2011 ***Note: The dates listed under Part C include MA and MA-PD plans. The dates listed under Part D sponsors also apply to MA and cost-based plans offering a Part D benefit.**		***Part C**	***Part D sponsors**	**Cost**	**Date earlier than last year**
September 30, 2011	CY 2012 standardized, combined Annual Notice of Change (ANOC)/Evidence of Coverage (EOC) is due to current members of all MA plans, MA-PD plans, PDPs and cost-based plans offering Part D. MA and MA-PD plans must ensure current members receive the combined ANOC/EOC by September 30th. Plans have the option to include Pharmacy/Provider directories in this mailing. All plans offering Part D must mail their LIS riders and abridged or comprehensive formularies with the ANOC/EOC to ensure current member receipt by September 30th. Exception: Dual Eligible SNPs that are fully integrated with the State must mail an ANOC with the SB for member receipt by September 30, 2011 and then send the EOC for member receipt by December 31, 2011. Fully Integrated Dual Eligible SNPs that send a combined, standardized ANOC/EOC for member receipt by September 30, 2011 are not required to send an SB to current members. Note: With the exception of the ANOC/EOC, LIS Rider, and abridged or comprehensive formularies, no additional materials may be sent prior to the beginning of when marketing activities may begin on October 1.	✓	✓	✓	✓

2012 MA, MA-PD, Part D and Cost-Based Plan Calendar **(All dates, unless identified as statutory, are subject to change)**					
2011 ***Note: The dates listed under Part C include MA and MA-PD plans. The dates listed under Part D sponsors also apply to MA and cost-based plans offering a Part D benefit.**		***Part C**	***Part D sponsors**	**Cost**	**Date earlier than last year**
October 1, 2011	Plans may begin CY 2012 marketing activities. Once an organization begins marketing CY 2012 plans, the organization must cease marketing CY 2011 plans through mass media or direct mail marketing (except for age-in mailings). Organizations may still provide CY 2011 materials upon request, conduct one-on-one sales appointments and process enrollment applications. Plans are required to include information in CY 2011 marketing and enrollment materials to inform potential enrollees about the possibility of plan (benefit) changes beginning January 1, 2012. Last day for Part D sponsors to request plan benefit package (PBP) plan corrections via HPMS.	✓	✓	✓	
October 1, 2011	Deadline for cost-based, MA, MA-PD and PDP organizations to request a plan correction to the plan benefit package (PBP) Deadline for cost-based, MA and MA-PD organizations to request SB hard copy changes	✓	✓	✓	

2012 MA, MA-PD, Part D and Cost-Based Plan Calendar **(All dates, unless identified as statutory, are subject to change)**					
2011 ***Note: The dates listed under Part C include MA and MA-PD plans. The dates listed under Part D sponsors also apply to MA and cost-based plans offering a Part D benefit.**		***Part C**	***Part D sponsors**	**Cost**	**Date earlier than last year**
October 2, 2011	Non-Renewal. The final beneficiary non-renewal notification letter must be a personalized letter and received by PDP, MA, MA-PD enrollees by October 1, 2011. PDP, MA, MA-PD organizations may not market to beneficiaries of non-renewing plans until after October 1, 2011. The non-renewal beneficiary notification must be received by beneficiaries no later than October 2, 2011. This year October 2 is a Sunday, which is non-mail day. Therefore, plans should take this into consideration when planning their mailings in order to make sure the beneficiary letters are sent far enough in advance so that they are received by this date. Additionally, CMS strongly encourages all organizations/sponsors to mail the beneficiary notification letters far enough in advance so that all beneficiaries have them before marketing begins on October 1, 2011.	✓	✓	✓	
October 6, 2011	Plan ratings go live on Medicare Plan Finder	✓	✓		
October 6, 2011	Tentative date for 2012 plan benefit data and plan drug benefit information to be displayed on Medicare Plan Finder (not applicable to EGWPs).	✓	✓	✓	
October 15, 2011	Part D sponsors must post PA and ST criteria on their websites for the 2012 contract year.		✓		

2012 MA, MA-PD, Part D and Cost-Based Plan Calendar **(All dates, unless identified as statutory, are subject to change)**					
2011 ***Note: The dates listed under Part C include MA and MA-PD plans. The dates listed under Part D sponsors also apply to MA and cost-based plans offering a Part D benefit.**		***Part C**	***Part D sponsors**	**Cost**	**Date earlier than last year**
October 15, 2011	2012 Annual Election Period begins. All organizations must hold open enrollment (for EGWPs, see Chapter 2 of the Medicare Managed Care Manual, Section 30.1). Medicare Marketing Guidelines require that all plans mail a CY 2012 EOC to each new member no later than when they notify the new member of acceptance of enrollment. Organizations offering Part D must mail their Low Income Subsidy Rider (LIS) and abridged or comprehensive formularies with the EOC for new members. Organizations may but are not required to provide new members with an effective date of January 1, 2012 or later with the ANOC portion of the standardized/combined ANOC/EOC	✓	✓		✓
November 2, 2011	Cost-Based organizations must mail the personalized final beneficiary non-renewal notification in time to be received by enrollees by November 2, 2011.			✓	
November 11, 2011	Notices of Intent to Apply (NOIA) for CY 2013 due for MA, MA-PD, PDPs, and "800 series" EGWPS and Direct Contract EGWPs	✓	✓	✓	
November – December, 2011	Non-Renewal. CMS to issue "close out" information and instructions to MA plans, MA-PD plans, PDPs, and cost-based plans that are non-renewing or reducing service areas.	✓	✓	✓	
December 1, 2011	Medicare cost-based plans not offering Part D must send the combined ANOC/EOC for receipt by members by December 1, 2011.			✓	
December 1, 2011	Non-Renewal. Cost-based plans must publish notice of non-renewal.			✓	

2012 MA, MA-PD, Part D and Cost-Based Plan Calendar **(All dates, unless identified as statutory, are subject to change)**					
2011 ***Note: The dates listed under Part C include MA and MA-PD plans. The dates listed under Part D sponsors also apply to MA and cost-based plans offering a Part D benefit.**		***Part C**	***Part D sponsors**	**Cost**	**Date earlier than last year**
December 7, 2011	Annual Election Period Ends	✓	✓		✓
December 31, 2011	Fully Integrated Dual Eligible SNPs that did not send an EOC with the ANOC by September 30, 2011, must send the EOC by December 31, 2011.	✓			
December 31, 2011	MAO SNPs must disenroll members: 1.) who enrolled prior to January 1, 2010 under the "disproportionate share" policy (i.e., the members did not meet the special needs criteria at the time of enrollment; or 2.) who were enrolled in a C-SNP as of January 1, 2010, but no longer met the special needs criteria as of that date.	✓			
2012					
January 1, 2012	Plan Benefit Period Begins	✓	✓	✓	
January 1 – February 14, 2012	Medicare Advantage Disenrollment Period (MADP)	✓			
January 4, 2012	Release of CY 2013 MAO/MAPD/PDP/SAE/EGWP applications	✓	✓	✓	
Mid January, 2012	Industry training on CY 2013 applications	✓	✓	✓	
January 31, 2012	Final Submission deadline for risk adjustment data with dates of service January 1, 2010 through December 31, 2010	✓		✓	
February 23, 2012	Applications due for CY 2013	✓	✓	✓	
March 2, 2012	Initial Submission deadline for risk adjustment data with dates of service January 1, 2011 through December 31, 2011	✓		✓	
September 7, 2012	Initial Submission deadline for risk adjustment data with dates of service from July 1, 2011 through June 30, 2012	✓		✓	

Part D Sponsor Bids and the Platino Program

When Part D sponsors seek to offer a plan in the Commonwealth of Puerto Rico as part of the Platino program, the Part D bids must reflect only basic benefits (i.e., defined standard, actuarial equivalent standard, or basic alternative design). Any supplemental benefits required by the Commonwealth (the Platino program's coverage of excluded drugs and/or cost-sharing buy-downs) should not be included as part of the plan sponsor's Part D bid. As discussed previously in our Call Letter for calendar year 2010, the supplemental benefits are negotiated between the Commonwealth and the Part D sponsor and are never part of the Medicare Part D bid submitted to CMS. CMS does not evaluate nor approve the Commonwealth's benefits provided by the Platino program.

CMS will revise the Health Plan Management System's (HPMS) Plan Benefit Package to reflect submissions of bids specific to the Platino program for 2012. Plan sponsors will not be able to validate bids for enhanced plans that apply to Platino programs.

Coordination of Benefits (COB) User Fees

CMS is authorized to impose user fees on Part D sponsors for the transmittal of information necessary for certain benefit coordination activities between sponsors and other entities providing prescription drug coverage. CMS may review and update this user fee annually to reflect the costs associated with such COB activities for the specific year. Since this user fee reflects the annual funding needs for COB-related activities, user fees vary (increasing or decreasing) yearly to reflect those needs. For contract year 2011, the Part D COB user fee was decreased to $1.17 per enrollee per year. In April 2011, CMS will implement the MARx Redesign and Modernization project which, among other changes, will enable daily enrollment transaction processing and reporting, multiple 4Rx spans within the beneficiary enrollment history, and reinstatement of erroneous disenrollments. These changes will significantly improve the timeliness and accuracy of information on beneficiary coverages. Some of the other functions financed through these fees include the operations of the TrOOP Facilitation Contractor (supporting real-time electronic E1, Nx and FIR transactions), the Coordination of Benefits Contractor (supporting the exchange and collection of information on other insurance or liability coverages for Medicare beneficiaries), and the facilitation of information on coverage gap discount program Part D drug cost reimbursements. Our projection of the incremental on-going costs of the COB-related activities to be carried out in 2012 indicates the Part D COB user fee must be increased to $1.62 per enrollee per year for contract year 2012. The 2012 COB user fee will be collected at a monthly rate of $0.18 for the first 9 months of the coverage year (for an annual rate of $0.135 per enrollee per month) for a total user fee of $1.62 per enrollee per year. Part D sponsors should account for this COB user fee when developing their 2012 bids.

ESRD Drugs

Effective January 1, 2011, the bundled prospective payment system (PPS) for renal dialysis services provided by an end-stage renal disease (ESRD) dialysis facility includes the limited number of oral equivalents of injectable drugs and biologics used in the treatment of ESRD that were formerly reimbursed under Part D. Therefore, sponsors are reminded that the costs related to these oral drugs with injectable equivalents must be excluded from the 2012 plan bids.

Submission of Quality Improvement Projects (QIPs) and Chronic Care Improvement Programs

Each MA organization that offers one or more MA plan must, for each of those plans, have an ongoing Quality Improvement (QI) Program that meets the applicable requirements of 42 CFR §422.152. CMS will request, on an annual basis, that QIPs and CCIPs be submitted for purposes of ongoing quality improvement monitoring. CMS does not anticipate a QIP and CCIP collection for CY 2011. However, the annual collection cycle for QIPs and CCIPs will begin with CY 2012. To ensure that these projects are evaluated in a consistent manner, CMS will require all plans, including those that have been deemed by an accrediting organization, to submit the QIPs and CCIPs for CY 2012 on the appropriate templates.

Guidance describing the QIP and CCIP templates, scoring methodology, benchmarks, and any CMS identified QIP and/or CCIP topics will be forthcoming. The guidance will also specify that in future years we anticipate that the project submission date may be earlier in the calendar year to allow sufficient time for CMS review.

Proposed Initiative to Promote Enrollment in Fully Integrated SNPs

In the draft 2012 Call Letter issued February 18, 2011, CMS solicited comments on a proposed initiative to promote enrollment of dual eligible beneficiaries in MA Special Needs Plans (SNPs) that integrate Medicaid and Medicare benefits. The initiative would be launched in 2013.

We asked for comment on key features, including the appropriate definition of "high quality" plan; design flexibilities that would promote care and streamline administration; incentives to promote plan participation; and appropriate consumer protections that would be a part of any such initiative. We appreciate the constructive comments and suggestions received, as well as concerns expressed. We will take these into consideration as we continue to develop this initiative. Additional details would be made available in separate guidance.

All Dual Eligible SNPs Required to Contract with State Medicaid Agencies

As required by section 164 of MIPPA and revised by section 3205 of the Affordable Care Act, starting in Contract Year 2013, all Dual Eligible Special Needs Plans (D-SNPs) will be required

to have contracts with the State Medicaid agencies in the States within which they operate. In the draft Call Letter, we announced that CMS is working to align the D-SNP State Medicaid Agency contract submission deadline with the MA Application deadline so that SNP approval can occur simultaneously with the MA contracting process. We solicited comment on a late February contract submission date.

In their comments, numerous D-SNPs and States objected to the proposed February contract submission deadline on the grounds that State budget and procurement rules do not allow States to execute contracts in February for the following calendar year. These commenters suggested that a February contract submission deadline would create significant hardships for D-SNPs and States, and serve as a barrier to operation for D-SNPs. We are currently taking these comments into consideration and developing operational policy that both reflects State budgetary and contracting timelines, and aligns this D-SNP contract submission deadline with the MA contracting process. We intend to publish operational guidance on the D-SNP State Medicaid Agency contract submission deadline for Contract Year 2013 in the future.

Involuntary Disenrollment of Ineligible or "Disproportionate Share" SNP Enrollees

As provided under MIPPA and section 3205(c) of the Affordable Care Act, SNPs may only enroll individuals who meet the plan's specific eligibility criteria; they may no longer enroll and serve a "disproportionate share" of individuals who do not meet the targeted criteria or condition. Also pursuant to MIPPA, chronic care SNPs (C-SNPs) may only enroll and serve individuals with certain chronic conditions, as specified by CMS.

Many SNPs currently include members: (1) who enrolled prior to January 1, 2010 under the "disproportionate share" policy (i.e., the members did not meet the special needs criteria at the time of enrollment); or (2) who were enrolled in a C-SNP as of January 1, 2010, but no longer met the revised special needs criteria as of that date. In both of these circumstances, rather than require the MAO offering these SNPs to involuntarily disenroll these members effective January 1, 2011 because they no longer met the SNP's targeted criteria, CMS required the MAOs to allow these individuals to continue to be enrolled through CY 2011. However, effective CY 2012, SNPs that include members who enrolled under the two circumstances described above will be required to disenroll those individuals if they do not request enrollment in a different plan prior to January 1, 2012. MAOs will not be permitted to transition these current enrollees into other MA plans offered by the organization. However, MAOs must retain any of these enrollees whose circumstances change and who regain special needs status prior to January 1, 2012.

Please refer to Section 14 of Appendix A1 of this Call Letter for guidance regarding the process for disenrolling ineligible members by January 1, 2012. The MAO must submit disenrollment transactions to MARx for those individuals who do not meet the plan's specific eligibility criteria, pursuant to instructions that CMS will release this year.

Please refer to the renewal plan guidance provided in this Call Letter for the notification requirements for current SNP enrollees other than those described above. Enrollees who will need to be disenrolled because they lose their special needs status in 2011 must be sent a disenrollment notice that includes information about other plan options, as well as additional details about Medigap rights and/or SEP rights, as applicable.[5] MAOs must retain any of these enrollees through their period of deemed continued eligibility, and also retain enrollees whose circumstances change and who regain their special needs status during such period, as described in section 50.2.5 of the MA Enrollment and Disenrollment Guidance.

MAO and PDP Sponsor Renewal/Non-Renewal Options for CY 2012

In this Call Letter, we provide detailed guidance regarding the plan renewal and non-renewal options available to MAOs and PDP sponsors for CY 2012. In addition, we clarify aspects of our non-renewal policies with respect to section 1876 cost contract plans.

As a result of business decisions, or pre- or post-bid discussions with CMS, MAOs and PDP sponsors may choose to change their current year offerings for the following contract year. Each year, current MAOs and PDP sponsors that continue their contracts are required to complete the Health Plan Management System (HPMS) Plan Crosswalk in a way that reflects Plan Benefit Package (PBP) renewal and non-renewal decisions and delineates, for enrollment purposes, the relationships between PBPs offered under each of their contracts for the coming contract year.

MAOs and Part D sponsors must also adhere to certain notification requirements, as specified in this guidance. While most renewal options must be completed using the HPMS Plan Crosswalk, there are limited exceptions to this requirement. These exceptions are described in Appendices A-1, A-2, B-1 and B-2. CMS will also provide precise technical instructions for completing the HPMS Plan Crosswalk for each MAO or PDP sponsor renewal or non-renewal option in the HPMS Bid Submission User Manual scheduled to be released on May 13, 2011.

Overall, this renewal and non-renewal guidance is based on two underlying principles: (1) the maximization of beneficiary choice; and (2) the protection of enrollment choices beneficiaries have previously made. We believe that beneficiaries should have the opportunity to make active enrollment elections into Original Medicare, a health care plan option, or a PDP option that best fits their particular needs.

As provided under 42 CFR 422.254, 422.256, 423.265, and 423.272, CMS reviews bids to ensure that an organization's or sponsor's plans in a service area are substantially different from those of other plans offered by the organization or sponsor in the area with respect to key plan

[5] Plans should note that the notification policy in this paragraph applies to those SNP enrollees who lost special needs status in 2011 *not* to disproportionate share enrollees who were not eligible for the SNP as of January 1, 2010.

characteristics such as premiums, cost-sharing, formulary structure, or benefits offered. In addition, under 42 CFR 422.506 and 423.507, we may non-renew plans that do not meet minimum enrollment thresholds after a specified length of time. This Call Letter contains information about how these requirements will be operationalized for CY 2012.

Although many of the renewal options outlined in this guidance are permissible despite year-to-year changes in benefits, premiums, and cost-sharing, we urge organizations and sponsors to maintain comparable benefits across contract years to the greatest extent possible in order to ensure that enrollees' enrollment elections remain valid. Section 3209 of the Affordable Care Act of 2010 provides CMS with authority to deny plan bids if an organization's or sponsor's proposed PBP includes significant increases in cost sharing or decreases in benefits offered. Refer to the "CY 2012 Cost Sharing Standards" section of this Call Letter for more information about how this requirement will be operationalized for CY 2012.

Appendices A-1, A-2, B-1 and B-2 outline all permissible renewal and non-renewal options for CY 2012 for MAOs and PDP sponsors, respectively, including their method of effectuation, systems enrollment activities, enrollment procedures, and required beneficiary notifications. Appendix C is a CMS model notice that corresponds to PDP scenario 6. CMS anticipates a release of model disenrollment notices that correspond to MAO scenarios 10, 13b, and 14 later this year.

Finally, the model termination notices associated with plan terminations or entire contract non-renewals will be released in August 2011 with instructions for non-renewing plans and contracts. MAOs offering special needs plans (SNPs) should note the options for SNP transitions, such as those involving renewing SNPs with ineligible or "disproportionate share" members and other transitions potentially affected by State contracting efforts. Organizations and sponsors should note that we have eliminated some exceptions that were allowed in previous years and modified previous options available under the HPMS Plan Crosswalk. Organizations and sponsors should also be aware that approval of a bid does not necessarily mean a submitted HPMS Plan Crosswalk or crosswalk exception meets CMS requirements and will be accepted by CMS. **If a renewal or non-renewal scenario is not outlined in Appendices A-1, A-2, B-1, or B-2, it is not a permissible renewal option.** Therefore, organizations and sponsors should submit their crosswalks and crosswalk exception requests as early as possible and contact CMS staff for clarification if there is any uncertainty about whether CMS requirements will be met and the exception will be granted. Organizations and sponsors are also urged to use this guidance to determine whether their renewal or non-renewal arrangements adhere to CMS standards. If CMS requirements are met, bids as well as HPMS Plan Crosswalks and crosswalk exceptions will be approved accordingly. Organizations and sponsors that have questions about their exceptions requests should contact Sara Silver, at sara.silver@cms.hhs.gov, and Heather Kilbourne, at heather.kilbourne@cms.hhs.gov, well before the bid submission deadline.

Each renewal and non-renewal option outlined in Appendices A-2 and B-2 includes, where applicable, instructions or deadlines for requesting particular renewal options that organizations and sponsors cannot themselves effectuate in the HPMS Plan Crosswalk. Organizations and sponsors will *not* be able to make changes to their HPMS Plan Crosswalks once bids are submitted to CMS on June 6, 2011. After that point, CMS will only make changes to organizations' and sponsors' HPMS Plan Crosswalks under exceptional circumstances.

Furthermore, any renewal options that require organizations and sponsors to submit crosswalk exception requests and manual enrollment transactions must be completed both correctly and completely pursuant to instructions that CMS will release later this year. A detailed timeline for HPMS Plan Crosswalks and crosswalk exception requests submissions will be included in forthcoming instructions. However, as stated above, organizations and sponsors should prepare their renewal and non-renewal options in advance so that they are able to submit any crosswalk and crosswalk exceptions as early as possible.

The June 6, 2011 deadline for bid submissions is incorporated in the *2012 MA, MA-PD, Part D and Cost-Based Calendar* at the beginning of this Call Letter. In addition, the calendar also lists June 6, 2011 as the deadline for MA plans, MA-PD plans, PDPs and Medicare cost-based contractors and cost-based sponsors to submit a CY 2012 full contract or partial contract (PBP) non-renewal or service area reduction notice to CMS. CMS will publish an HPMS memorandum, to be released this summer, providing non-renewal and service area reduction guidance and required termination model beneficiary notices. Organizations and sponsors should refer to this forthcoming memorandum for more information about full-contract non-renewal and plan termination processes.

Section 2 – Improving Information Sharing & Transparency with Sponsors

Clarification of Parent Organization Information for MA Organizations and PDP Sponsors

CMS is increasingly focused on the relationship between MA organizations and PDP sponsors and their parent organizations in our administration of the Part C and D programs. For example, CMS makes auto-enrollment and reassignment determinations by allocating enrollees among PDP sponsors' parent organizations, not among the sponsors themselves. Also, in certain situations, CMS will look to an MA organization's parent organization to make a determination concerning its qualification for quality bonus payments. Therefore, it is crucial that all MA organizations and PDP sponsors accurately report their parent organization status to CMS and keep such information up-to-date in CMS records.

CMS considers a parent organization to be the legal entity that owns a controlling interest in a PDP sponsor or MA organization (both referred to as "contracting organizations"). More specifically, for Part C and D reporting purposes, the parent organization is the "ultimate" parent,

or the top entity in a hierarchy (which may include other parent organizations) of subsidiary organizations which is not itself a subsidiary of any corporation.

CMS is providing this clarification in part because there have been instances where contracting organizations have reported information concerning their immediate parent rather than their ultimate parent. Such inaccuracies create the risk that CMS makes incorrect program implementation determinations or conducts duplicative work.

CMS acknowledges that in fact many contracting organizations are not subsidiaries to a parent company. However, for purposes of program administration, CMS must have a parent organization name associated with each contracting organization. Therefore, when applicable, contracting organizations should identify themselves as their own "parent organization" in CMS records.

All contracting organizations are required to report parent organization information to CMS as part of their applications for qualification for a Medicare contract. CMS has also provided guidance through HPMS to organizations alerting them to their obligation to keep such information up-to-date in our records. As part of this effort, contracting organizations must pay special attention to the impact of changes of ownership among entities in their corporate ownership chain that may have an effect on the identity of the contracting organization's ultimate parent. Also, contracting organizations should always be prepared to provide the most conclusive documentation available to them of their relationship to their parent organization upon request from CMS. Such documentation may consist of financial statements, articles of incorporation, contracts, or filings with regulatory authorities.

Contracting organizations can view their parent organization assignments within the Basic Contract Management Module in HPMS. The parent organization assignment can be accessed using the following navigation path: Contract Management > Basic Contract Management > Select Contract Number > Plan Management Data. Parent organization data is also available in the General Information Report under Contract Reports and in the Plan Version of the Contract Information Data Extract. Contracting organizations do not have access rights to change the parent organization designation, but rather must report changes to CMS.

While CMS will continue to issue annual requests to contracting organizations to provide updates to CMS concerning the name of the parent organization, effective immediately, we are now requiring contracting organizations to proactively report all parent organization changes to CMS within 30 days of the effective date of such a change. All such change requests must be emailed to drugbenefitimpl@cms.hhs.gov with the subject line of "Parent Organization Update." Contracting organizations should include with the email supporting documentation, such as one or more of the items listed above. CMS may request additional supporting documentation, if

necessary. Of note, due to character limitations, CMS will not necessarily agree to all minor changes, such as requests to expand abbreviations.

Prescriber Identifiers

This section provides guidance regarding how Part D sponsors handle prescriber identifiers on Part D claims and PDE records; the first section responds to questions we have received on how sponsors should currently handle identifiers for prescribers from jurisdictions other than U.S. states and territories, where allowed under state law; the remaining sections concern permissible prescriber identifiers on Part D claims and PDE records in 2012 and 2013.

Foreign Prescriber Identifiers: In an August 13, 2010 memorandum on the use of prescriber identifiers on Medicare Part D drug claims, we reiterated the CMS guidance that specifies that the NPI is intended to uniquely identify a health care provider in standard transactions, such as health care claims. The Health Insurance Portability and Accountability Act of 1996 (HIPAA) requires that covered entities use NPIs in standard transactions by the specified compliance dates. The NPI is the only health care provider identifier that covered entities may use to identify health care providers. Although HIPAA requires pharmacies to use the NPI on HIPPA standard transactions, we recognize that pharmacies cannot always obtain the prescriber NPI at the time of dispensing. Therefore, to ensure Part D enrollees do not experience service interruptions, CMS guidance permits Part D sponsors to accept alternative prescriber identifiers, such as DEA registration numbers or state license numbers. However, we clarified that it is our intention that whatever type of prescriber identifier (i.e., NPI, DEA number, unique provider identification number (UPIN) or state license number) is used, it must be a valid number.

After this guidance was issued, we received comments indicating that a number of States permit pharmacies to fill prescriptions written by foreign (i.e., non-U.S. - licensed) prescribers. We have been asked what prescriber identifier should be required on the Part D claim and submitted on the prescription drug event (PDE) record. If a prescription has been written by a foreign prescriber, the sponsor should require the use of the license number assigned by an appropriate licensing board in the foreign jurisdiction in which the prescriber practices/resides on the claim with the State license qualifier. We understand that the use of this qualifier is not inconsistent with the National Council for Prescription Drug Programs (NCPDP) data dictionary, which defines a State license number as a number assigned and required by a State Board or other State regulatory agency. In the absence of a reference to "U.S." in the NCPDP definition and given the Webster's dictionary definition of "state" as one of the territorial and political units constituting a federal government, we believe State license is the most appropriate qualifier to use for foreign prescribers.

Permissible Prescriber Identifiers in 2012: For 2012, CMS will continue to permit Part D sponsors to report on the PDE records any one of the four currently acceptable types of

prescriber identifiers; that is NPI, DEA number, UPIN or state license number. Sponsors must ensure that these identifiers are active and valid. However, sponsors should not reject a pharmacy claim solely on the basis of an invalid prescriber identifier unless the issue can be resolved at point-of-sale. Thus, pharmacies can fill prescriptions and sponsors can pay the associated drug claims with an unvalidated prescriber ID at point-of-sale. However, sponsors are then responsible for verifying and reporting a valid prescriber ID on the PDE record and, whichever type of identifier is reported in the PDE, the identifier must be valid. Therefore, if a valid prescriber ID is not included on the Part D claim, either the sponsor, or the pharmacy if in accordance with the contractual terms of the network pharmacy agreement, must follow up retrospectively to acquire a valid ID of one of the four acceptable types before the PDE is submitted.

Follow-up may require review of the prescription, contact with the prescriber, use of the multiple sources of state and federal data on providers, or the purchase of prescriber ID validation services from a commercial vendor. Among the available state and federal sources are individual state licensing board data on licensing and sanctions, Drug Enforcement Agency registrant files, the Social Security Administration death file, OIG and state Medicaid program excluded provider lists, and the CMS National Plan & Provider Enumeration System (NPPES) database. Periodically updated files are available from these databases, in some cases directly from these agencies, or else wise through the Department of Commerce's National Technical Information Service (NTIS). In addition to these resources, we understand that multiple commercial firms compile databases and offer services for validation of prescriber identifiers, so an alternative approach would be for sponsors to purchase prescriber identifier validation services from commercial vendors who already have access to these sources of data and are currently providing these services to pharmacy, health plan, and pharmaceutical manufacturer clients. In an exception to this requirement, we agree with commenters that foreign prescriber identifiers cannot be similarly validated, and thus it will be permissible to submit foreign prescribers' license numbers obtained from the prescription or prescriber without validation against any official database.

Thus, sponsors have the option to either build their own systems or contract with commercial vendors for prescriber ID validation services. Although we impose the requirement for validation of prescriber identifiers on Part D sponsors, we expect that network pharmacies will either contractually agree to provide some of these services themselves or will fully support any retroactive review of the prescription and other pharmacy records necessary to retrospectively identify the prescriber and obtain a valid identifier. We leave the terms and conditions for responsibilities for these processes and any penalties for failure to perform to contractual negotiations between the sponsor or its agent and the network pharmacies. However, we do expect that any requirement for a pharmacy to acquire and utilize its own automated validation capability will be arrived at only through mutual agreement, since such a requirement may be impractical for many smaller pharmacy organizations.

For 2012, we will also extend the requirement for a valid prescriber identifier to be reported on the PDE record to non-standard format claims, such as requests for reimbursement ("paper" claims) submitted by Medicare beneficiaries. We received numerous questions concerning the approach sponsors are expected to use to process beneficiary submitted requests for reimbursement. For 2012, sponsors may require members to furnish the prescriber's name and address or phone number, or the pharmacy information, to assist the sponsor in obtaining the prescriber ID. However, payment to the beneficiary cannot be made dependent upon the sponsor's acquisition of the prescriber ID, itself. Consistent with current guidance, sponsors may withhold reimbursement to the beneficiary only if there is a reason to suspect fraud or if there are coverage issues. Once the prescriber or pharmacy contact information is acquired, the sponsor must process the request for reimbursement and the sponsor, or the pharmacy (if doing so is in accordance with their contract terms), must follow up retrospectively to acquire a valid ID. Follow-up may entail a review of the prescription, prescriber contact, use of state or federal data on providers, or purchase of prescriber ID validation services from a commercial vendor. In the absence of fraud, if the sponsor is unable to retrospectively acquire a valid prescriber ID, the sponsor may not seek recovery of the Part D payment from the beneficiary.

CMS will begin validating the format of all prescriber identifiers on PDEs that are coded as an NPI and will exclude from payment reconciliation PDEs with invalid NPIs. We will also be assessing each sponsor's performance regarding NPI use and validity and will be notifying plan sponsors of their performance level. While this section has specifically addressed prescriber identifiers, we remind both Medicare Advantage Organizations and Part D Sponsors that they are also required to obtain valid provider NPIs on claims. NPIs may be deactivated for reasons such as provider death or fraud related to identity theft and other forms of fraud. The NPPES database is updated monthly to reflect these changes. Therefore, in addition to verifying the reported NPI is valid, Part C and D plan sponsors must also periodically confirm the identifiers are active. In those instances when the NPI is found to have been deactivated, the sponsor must follow up with the provider to determine the reason for the deactivation.

In 2012, we will also impose additional requirements on plan sponsors with regard to Part D claims for all controlled substances (not just Schedule II drugs as described in our proposed Call Letter). Effective January 1, 2012 Part D sponsors will be required to confirm the validity of DEA numbers on Schedule II-V drug claims or map NPIs on these claims to the prescriber's DEA numbers. In addition, sponsors will be required to confirm that the controlled substance is within the prescriber's scope of practice to prescribe. As noted above, sources of state and federal data on providers are available to support sponsor efforts to ensure a prescriber ID is valid and to verify Schedule II-V drugs are within the prescriber's scope of practice. This policy does not supersede or alter pharmacy obligations relative to DEA registrants under the Controlled Substances Act and DEA rules. Again, in addition to these resources, we understand that multiple commercial firms compile databases and offer services for validation of prescriber identifiers, so an alternative approach would be for sponsors to purchase prescriber identifier

validation services from commercial vendors who already have access to DEA data and are currently providing these services, including whether the provider has authorization to prescribe controlled substances, to pharmacy, health plan, and pharmaceutical manufacturer clients.

Permissible Prescriber Identifiers in 2013: Finally, we are considering proposing a regulatory change that will limit acceptable prescriber identifiers on Part D claims and PDE records in 2013 to only the individual NPI. In other words, a prescription written by an individual prescriber who did not acquire an individual NPI and disclose it to the pharmacy on the prescription or otherwise would not be filled under the Part D program. Since all practitioners who are authorized to prescribe Part D drugs under applicable U.S. state laws can acquire an individual NPI from HHS, we do not believe that this will present a significant barrier to access to Part D drugs for Medicare beneficiaries. Moreover, consistent use of a single validated identifier will enable CMS to provide better oversight over possible fraudulent activities. We received numerous comments recommending CMS restrict Part D prescriptions to U.S.-licensed prescribers, and we are taking this under consideration.

Supplemental Formulary File Submission

The regulation at 42 CFR § 423.272(b)(2) requires that CMS review bids to ensure that the plan designs are not likely to substantially discourage enrollment by certain Part D eligible individuals. Part D sponsors offering partial tier gap coverage, free first fill coverage, home infusion bundling under Part C, coverage of excluded drugs, or coverage of over-the-counter (OTC) drugs under utilization management programs must submit the corresponding required supplemental formulary file(s) as part of their bid submission so that CMS can assess whether or not the plan design meets the non-discrimination requirements as described under 42 CFR § 423.272(b)(2). We are requesting that these supplemental formulary files be submitted no later than June 13, 2011. Given the reduced time frame for review and approval of bids, CMS will not have sufficient information to fully evaluate whether a plan's benefit design meets the non-discrimination requirements if sponsors do not submit these supplemental files in a timely manner. Therefore CMS will assume that if a sponsor does not submit the appropriate supplemental files by the June 13th deadline, then the sponsor does not intend to offer these supplemental benefits and will be asked to revise their bids accordingly. In addition these plans will be subject to a compliance action and will be at risk of having their bids disapproved.

Preventing Part D Payment for Hospice Drugs

Hospice programs, as specified in section 1861(dd) of the Social Security Act and in Federal regulations at Part 418, must provide individuals under hospice care with drugs and biologicals related to the palliation and symptom management of the terminal illness as defined in the hospice plan of care. The only drugs covered by the hospice program are those used primarily for relief of pain and symptom control related to the individual's terminal illness. However,

because hospice care is a Medicare Part A benefit, the drugs provided by the hospice and covered under the Medicare per-diem payment to the hospice program are not covered under Part D.

Our October 23, 2010 memorandum entitled, "Preventing Part D Payment for Hospice Drugs," incorrectly stated that all Part D sponsors currently do not have the ability to identify any Medicare enrollees who have elected hospice. In fact, CMS has been sending beneficiary-level hospice data to all Part D sponsors. These data are currently sent on the transaction reply report (TRR) at the time of the beneficiary's enrollment and subsequently whenever the hospice information changes. As specified in the Plan Communications User Guide, the TRR includes a hospice indicator in position 54 and, in positions 85-96, a hospice start date and, if applicable, hospice termination date. The associated transaction reply codes are 071- Hospice status set and 72- Hospice status terminated. Sponsors need to ensure their claims processor is notified of an enrollee's hospice election and that processes are in place to prevent Part D payment for hospice drugs.

We have received requests for further guidance regarding how sponsors should identify hospice drugs and questioning whether sponsors should establish a point-of-sale prior authorization edit or to pay the claim at point-of-sale and make a retrospective Part A vs. D payment determination. We are currently working with the CMS hospice staff to develop clarifying guidance that will be issued at a later date. In the interim, sponsors need to ensure their claims processor is notified of an enrollee's hospice election. Additionally, we suggest that unless the plan has information available at point-of-sale to determine payment responsibility, sponsors should pay the claims for drugs furnished to members enrolled in a hospice program that may be covered under the hospice benefit and retrospectively determine payment responsibility.

Employer Group Waiver Plans and Application of the Manufacturer Discount

Section 1860D-14A(c)(2) of the Social Security Act specifies that if a Part D sponsor offers supplemental Part D coverage, the manufacturer discount will not be applied until after such supplemental coverage has been applied to the applicable drug. Therefore, CMS announced in a June 2, 2010 HPMS memorandum to all Part D sponsors that the value of supplemental benefits provided as part of a Part D enhanced benefit, including benefits negotiated between EGWP sponsors and employers, must be calculated prior to the application of the Medicare manufacturer coverage gap discount. Until such time CMS can systematically collect supplemental benefits information as part of the EGWP PBP within HPMS, the chief financial officer of the Part D sponsor is required to attest, as part of its contract with CMS, that if the sponsor provides supplemental coverage via any of its enhanced benefit plans, it will apply the manufacturer coverage gap discount only after the plan's supplemental benefits have been applied. Sponsors are also required to attest to the accuracy of the discount amounts submitted

on the prescription drug event (PDE) data and provide documentation, upon request, to CMS's third party administrator (TPA) when required.

CMS will be developing an information collection effort to ensure Part D EGWP sponsors have correctly applied the manufacturer discounts to covered Part D drugs. This information collection effort would require Part D sponsors submit the Part D supplemental benefits negotiated between employers and EGWPs. The information collected by CMS would be available in the event CMS received other indications that an EGWP was not compliant with the administration of the manufacturer discount. More information will be communicated to Part D sponsors regarding the information collection process, including any modifications to existing EGWP waivers, in upcoming memoranda.

Quality Reporting Requirements for Employer/Union-Only Direct Contracts

Currently, Medicare Advantage (MA) contracts are required to collect and report to CMS quality measurement data from the Healthcare Effectiveness Data and Information Set (HEDIS), Medicare Health Outcome Survey (HOS), and Consumer Assessment of Healthcare Providers and Systems (CAHPS). All stand-alone Prescription Drug Plans (PDPs) are required to collect and report CAHPS data to CMS. To date, the Employer/Union Only Direct contracts have been excluded from the quality reporting requirements. Beginning in 2012 all Employer/Union Only Direct contracts will be required to meet the same reporting requirements as MA or PDP contracts. For example, the Employer/Union Only Direct Private Fee-for-Service (PFFS) contracts will be required to collect and report HEDIS, HOS and CAHPS data to CMS. Employer/Union Only Direct MA contracts can see the HPMS memo "2011 HEDIS, HOS and CAHPS Measures for Reporting on Medicare Advantage Organizations" dated November 4, 2010 as an example of the MA reporting requirements for 2011. Employer/Union Only Direct PDPs can view the CAHPS reporting requirements at www.ma-pdpcahps.org.

Improvements to Plan Ratings

CMS is committed to continuing to improve the Part C and D quality performance measurement system to increase focus on improving beneficiary outcomes, beneficiary satisfaction, population health, and efficiency of health care delivery. To that end, CMS has been working on developing a more robust system to measure quality and performance of Part C and D contracts. As new measures are developed and adopted, they will be incorporated into the Plan Ratings published each year on the Medicare Plan Finder website and used to determine star ratings for quality bonus payments.

CMS views the MA quality bonuses also referred to as value-based payments as an important step to revamping how care and services are paid for, moving increasingly toward rewarding better value, outcomes, and innovations. As we add measures to the Plan Ratings over time, we will consider the following principles:

- Public reporting and value-based payment systems should rely on a mix of standards, process, outcomes, and patient experience measures, including measures of care transitions and changes in patient functional status. Across all programs, CMS seeks to move as quickly as possible to the use of primarily outcome and patient experience measures. To the extent practicable and appropriate, outcomes and patient experience measures should be adjusted for risk or other appropriate patient population or provider characteristics.

- To the extent possible and recognizing differences in payment system maturity and statutory authorities, measures should be aligned across Medicare's and Medicaid's public reporting and payment systems. CMS seeks to evolve to a focused core-set of measures appropriate to the specific provider category that reflects the level of care and the most important areas of service and measures for that provider.

- The collection of information should minimize the burden on providers to the extent possible. As part of that effort, CMS will continuously seek to align its measures with the adoption of meaningful use standards for health information technology (HIT), so the collection of performance information is part of care delivery.

- To the extent practicable, measures used by CMS should be nationally endorsed by a multi-stakeholder organization. Measures should be aligned with best practices among other payers and the needs of the end users of the measures. Our strategy is to continue to adopt measures that are nationally endorsed and are in alignment with the private sector as we do today through the use of measures developed by the National Committee for Quality Assurance (NCQA) and the Pharmacy Quality Alliance (PQA), and the use of measures that are endorsed by the National Quality Forum (NQF).

As we modify the calculation approaches for the Plan Ratings, we are incorporating the following principles:

- Plans should be scored on their overall achievement relative to national or other appropriate benchmarks. In addition, scoring methodologies should consider improvement as an independent goal.

- Measures or measurement domains need not be given equal weight, but over time, scoring methodologies should be more weighted towards outcome, patient experience and functional status measures.

- Scoring methodologies should be reliable, as straightforward as possible, and stable over time and enable consumers, providers, and payers to make meaningful distinctions among providers' performance.

Using the principles discussed above, CMS has identified a set of enhancements for the 2012 and 2013 Plan Ratings. For the 2012 Plan Ratings we are considering the following measures to be added to the existing set used in the 2011 Plan Ratings:

- All-Cause Readmission rates. (For more information about this measure, see HEDIS® 2011 Technical Specifications, Volume 2.) These items would be case-mix adjusted.
- Advising Smoker and Tobacco Users to Quit. This information is collected through the CAHPS survey. (For more information about this measure, see HEDIS® 2011 Technical Specifications, Volume 2.). CMS views survey data from beneficiaries as a complement to administrative and clinical data. CAHPS data have been found to display high reliability and acceptable validity at the contract level (Hargraves et al., 2003).
- Body Mass Index. (For more information about this measure, see HEDIS® 2011 Technical Specifications, Volume 2.)
- Special Needs Plan (SNP)-specific measures. This would include three rates included as part of the Care for Older Adults measure that has been collected for the past three years. These would only apply to contracts that have a SNP plan. The three rates being considered are medication review conducted by a prescribing practitioner or clinical pharmacist and the presence of a medication list in the medical record; functional status assessment; and pain screening or pain management plan. (For more information about this measure, see HEDIS® 2011 Technical Specifications, Volume 2.)
- Voluntary Disenrollment Rates. (see 2011 Display Measures – Technical Notes at www.cms.gov/PrescriptionDrugCovGenIn/06_PerformanceData.asp)
- Measures from the Hospital Inpatient Quality Reporting program (formerly known as Reporting Hospital Quality Data for Annual Payment Update). (See http://www.qualitynet.org/dcs/ContentServer?c=Page&pagename=QnetPublic%2FPage%2FQnetTier3&cid=1138900298473 for a list of measures.) CMS is exploring whether the individual-level hospital data can be associated with individual MA contracts.
- Appropriate implementation of Part D transition processes by plans to ensure continuity of care for beneficiaries. Additional information on this measure will be provided as it becomes available.
- Part D Medication Adherence. This measure would use the proportion of days covered methodology as endorsed by PQA. (Several potential adherence measures are currently posted on the display measures page at http://www.cms.gov/PrescriptionDrugCovGenIn/06_PerformanceData.asp.)

For SNP-specific measures, CMS is examining the feasibility of creating a methodology to incorporate SNP-specific measures into Plan Ratings, including for contracts that have a mix of SNP and non-SNP plans. Additionally, CMS is considering differential weighting to individual measures. Currently all items used in Plan Ratings are given equal weight. A table with the data time frame for each of the measures is now included in the technical notes at www.cms.gov/PrescriptionDrugCovGenIn/06_PerformanceData.asp. CMS is continuing to explore the feasibility of MA and fee for service comparisons.

For all of the measures, CMS will be examining the quality of the data, variation among plans, and the measure's accuracy and validity before making a final determination about inclusion.

For example, for the all-cause readmission rate we will look at the quality of the data reported in June 2011 to make a final decision about whether this measure is incorporated into the 2012 Plan Ratings or the 2013 Plan Ratings. For those measures that are not proven to be reliable and valid, CMS will determine whether such measures may be appropriate "display measures", which would not be used in the plans' star ratings.

CMS is also considering using the same 4-star thresholds that were set for the 2011 Part C and D Plan Ratings. (See http://www.cms.gov/PrescriptionDrugCovGenIn/06_PerformanceData.asp for the current thresholds.) Plans should be aiming to achieve at least the 4-star thresholds which are absolute. Four-star thresholds define expectations about what it takes to be a high-quality contract and drive quality improvement. For the 2011 Plan Ratings, measures that were new or were not part of the Plan Ratings for at least two years did not receive a 4-star threshold. For 2012 and beyond, CMS will be setting 4-star thresholds for measures with at least a two year data history. For example, we will be providing sponsors with the 4-star thresholds (through an HPMS memo) for the following measures: availability of TTY/TDD services and foreign language interpretation and accuracy of information members get when they call the health plan.

Additional enhancements under consideration for the 2012 Part C and D Plan Ratings include:

- Weighting of the measures to provide greater weight to clinical outcomes and lesser weight to process measures such as call center measures,
- Controlling for the concentration of providers in a geographic area, such as Health Professional Shortage Areas (HPSAs),
- Rewarding contracts for quality improvement, and
- Reducing the overall and/or summary Plan Ratings for contracts with serious compliance issues. Serious compliance issues will be defined as situations where CMS curtails enrollment or marketing of new enrollees. A serious compliance sanction in effect as of August 31, 2011 will reduce the 2012 overall and/or summary Plan Ratings published in October 2011. If a contract has a serious compliance issue that occurs between September 1, 2011 and March 31, 2012, the 2012 Plan Ratings will be updated to reflect this issue.

For the 2013 Plan Ratings we are considering adding the following measures:

- Survey measures of care coordination. We are considering adding a set of survey items to the CAHPS survey that will be administered in 2012. We will let sponsors know the set of items through an HPMS memo once they are finalized. We are also working on a Chinese translation of the CAHPS survey instrument.
- Case-mix adjusted mortality rates.
- Preventable hospitalizations.

- Serious Reportable Adverse Events, including Hospital Acquired Conditions. (See the Part C Reporting Requirements posted at www.cms.gov/HealthPlansGenInfo/16_ReportingRequirements.asp.)
- Grievances. (See the Part C Requirements posted at www.cms.gov/HealthPlansGenInfo/16_ReportingRequirements.asp and Part D Reporting Requirements posted at http://www.cms.gov/PrescriptionDrugCovContra/08_RxContracting_ReportingOversight.asp.
- Use of highly rated hospitals by plan members. This will combine information about the use of hospitals by plan members with the total performance score that will be calculated for each hospital as part of Hospital Value-based Purchasing. The total performance score is proposed as part of the Notice of Proposed Rulemaking, "Medicare Program; Hospital Inpatient Value-Based Purchasing Program", published on January 7, 2011.
- Medication therapy management (MTM) measures related to comprehensive medication reviews.
- Evaluation of a contract's Chronic Care Improvement Program (CCIP) and Quality Improvement Project (QIP).

On a regular basis, the Medicare Health Outcomes Survey (HOS) engages in a process of review and refinement to ensure that it is benefiting from the latest advances in survey design, outcomes assessment, psychometrics, and performance measurement. We are currently anticipating the implementation of HOS 3.0 in 2013. As HOS is a HEDIS® Effectiveness of Care Measure, revisions will follow the standard NCQA protocol for HEDIS® measure refinements.

We will provide as much advance notice of these changes to the Plan Ratings as possible, but sponsors are encouraged to take proactive steps to put in place quality assurance efforts in these areas in order to have a head start in effecting improved outcomes. Going forward, we plan to announce potential measures two years in advance. CMS will provide Sponsors the opportunity to comment on proposed changes to the plan rating system later this year.

Section 3 – Improving Beneficiary Protections

I. General

Contracting Organizations with Ratings of Less Than Three Stars in Three Consecutive Years

CMS has previously stated publicly that we consider contracting organizations (i.e., MA organizations and PDP sponsors) with less than an "average" or three-star summary plan rating to be out of compliance with the requirements of the Part C or D programs. For example, in the preamble to our notice of proposed rulemaking published in the Federal Register on October 22, 2009, we stated that, "organizations and sponsors with less than 'good' ratings should expect to

be the subject of our monitoring and compliance actions." We also made a similar statement in the 2009 Call Letter.

CMS cannot continue to contract with organizations whose performance is consistently out of compliance with Medicare requirements. Contracting organizations should interpret a less than "average" (or three-star) summary rating on either their Part C or D performance to be a notice from CMS that they are to take corrective action to come into compliance with program requirements. Also, within the last year, CMS adopted and will continue a policy of issuing formal compliance notices each year to all sponsors that earned low ratings for that year.

CMS considers organizations that fail for three straight years to achieve at least a three-star summary rating on Part C or D to have ignored over a significant period of time their obligation to meet program requirements and to be substantially out of compliance with their Medicare contracts. These organizations should expect CMS to initiate action to terminate their contracts following 1) our publication of the set of annual plan ratings that assigns the organization its third consecutive summary rating of less than three stars and 2) our confirmation that the data used to calculate the star ratings reflect the sponsor's substantial non-compliance with Part C or Part D requirements. CMS would pursue such actions in a manner consistent with our existing statutory and regulatory Part C and D contract termination authority.

Special Election Period for Enrollment in 5-Star MA plans and PDPs

On November 19, 2010, in an HPMS memorandum entitled "Establishing a Special Election Period (SEP) to Enroll in 5-star Medicare Advantage Plans in Plan Year 2012," CMS announced the establishment of an SEP that will allow Medicare beneficiaries eligible for MA plans to enroll in 5-star MA plans at any point during the year. As indicated in the November 19 memorandum, we are providing additional guidance about the new SEP through this call letter.

After consideration of the comments received on the draft call letter, we are making two changes to the scope of the SEP. First, we have expanded the scope of the SEP to include 5-star PDPs, as well as MA plans (including MA-PDs). In addition, we are clarifying that all eligible individuals, including those who are currently in a 5-star MA plan or PDP, may use the SEP to enroll in a new 5-star PDP or MA plan.

Thus, consistent with these changes, the general parameters of the SEP are as follows:

- The SEP is applicable to MA plans and PDPs with an overall plan summary rating of 5 stars regardless of the rating used for purposes of annual quality bonus payments. The summary star rating is provided by CMS prior to the Annual Election Period (AEP) and is effective for the following contract year (January – December).

- The new SEP will apply only for purposes of enrolling in a 5-star MA plan or PDP plan; it cannot be used to enroll in other types of plans (such as section 1876 or 1833 plans). Any individual who meets the applicable MA or PDP eligibility requirements may use the new SEP to enroll in a 5-star PDP or MA plan. However, the SEP does not convey any additional right to select other coverage outside of the normal enrollment periods. Thus, if an individual who is currently enrolled in an MA-PD chooses to instead enroll in a 5-star PDP, that individual must receive his or her health coverage through Original Medicare until the next valid enrollment period. Similarly, if such an individual chooses to instead enroll in a 5-star MA-only plan, that individual could not again elect drug coverage until the next valid enrollment period.
- The annual SEP will be available beginning on December 8, 2011. Enrollment requests made using this SEP will be effective the first of the month following the month the enrollment request is received (January 1 – December 1). Once an individual enrolls in a 5-star MA plan or PDP using this SEP, the individual's SEP ends for that plan year, and the individual will be limited to making changes only during other applicable election periods (e.g., annual enrollment period or another valid SEP). Individuals will be able to enroll in 5-star MA plans and PDPs directly through the plan, or through 1-800-MEDICARE or Medicare.gov.
- Since 5-star ratings are awarded on a calendar year basis, the effective dates of enrollments requested using this SEP are limited to January 1 through December 1 of the calendar year in which the plan has the 5-star rating.
- Plans that have received an overall 5-star rating will be required to accept these SEP requests, similar to any other enrollment request, unless the plan is closed per a CMS-approved capacity limit.
- The SEP is not available to enroll in a plan that does not have an overall 5-star rating, even if the plan receives 5 stars in some rating categories, or if the plan is in the same parent organization.

CMS plans to create a new SEP indicator to be used for plan submitted enrollment transactions and to track the utilization of this SEP. Details on the new indicator will be included in a future CMS system release announcement later in 2011.

II. Part C

Duplicative Plans and Plans with Low Enrollment

The following guidance applies to non-employer MA plans, Chronic Care Special Needs Plans (C-SNPs) and Institutional Special Needs Plans (I-SNPs). Dual-Eligible Special Needs Plans (D-SNPs) remain subject to low enrollment guidance but are excluded from meaningful difference evaluation. Note: We reserve the right to review employer plans for low enrollment and/or meaningful difference in future years.

The large number of MA plan options that have been offered in many areas has made it difficult and confusing for beneficiaries to distinguish between these plans and to choose the best option to meet their needs. MAOs should not submit CY 2012 bids for plans that have insufficient enrollment and/or are not meaningfully different from their other plan offerings in the area.

In 42 CFR § 422.254(a)(5) and 422.256(b)(4)(i), we specify that CMS reviews bids to ensure that an MAO's plans in a given service area are meaningfully different from one another in terms of key benefits or plan characteristics such as cost sharing, benefits offered, or plan type. Using our authority under section 1857(c)(2)(B) of the Act and 42 CFR §422.506(b)(1)(iv), CMS may non-renew plans that do not have sufficient enrollment after a specified length of time. CMS will address low enrollment and duplicative plans for CY 2012 with two separate processes, as described below.

A. Plans With Low Enrollment

During April or May 2011, CMS will send each MAO a list of low enrollment plans that have been in existence for three or more years but, as of April 2011, have fewer than 500 enrollees for non-SNP plans and 100 enrollees for SNP plans. The lists will not include low enrollment plans that CMS determines are located in service areas that do not have a sufficient number of competing options of the same plan type.

Under out authority at 42 CFR §422.506(b)(1)(iv), MAOs must provide a justification for each of the identified low enrollment plans or confirm through return email that the plan will be eliminated or consolidated with another of the organization's plans for CY 2012. If CMS does not find that there is a unique or compelling reason for maintaining a plan with low enrollment, CMS will non-renew the plan. Instructions for how to submit business cases, the timeframe for submissions, and what information is required in those submissions will be included with the list of low enrollment plans sent to the MAO.

CMS recognizes there may be reasonable factors, such as specific populations served and geographic location, which lead to a plan's low enrollment. SNPs, for example, may legitimately have low enrollments because of their focus on a subset of enrollees with certain medical conditions. We will consider all such information when evaluating whether specific plans should be non-renewed based on insufficient enrollment. MAOs are to follow the CY 2012 renewal/non-renewal guidance in this Call Letter to determine whether a low enrollment plan may be consolidated with another plan(s).

B. Duplicative Plan Offerings

MAOs offering more than one plan in a given service area should ensure that beneficiaries can easily identify the differences between the plans and determine which plan provides the highest

value at the lowest cost based on their needs. For CY 2012, CMS will use plan-specific out-of-pocket cost (OOPC) estimates to identify meaningful differences among similar plan types. OOPC estimates are based on a nationally representative cohort of Medicare beneficiaries represented in the Medicare Current Beneficiary Survey data and are used to provide estimated plan cost information to beneficiaries on Medicare Options Compare. Estimated out-of-pocket costs for each plan benefit package are calculated on the basis of utilization patterns for that cohort. The calculation includes Parts A, B, and D services and certain mandatory supplemental benefits, but not optional supplemental benefits. For purposes of evaluating meaningful differences among MA plans, CMS will exclude premiums from the OOPC calculation. Current enrollment and risk scores will not affect the OOPC calculation. A summary of the OOPC estimates is available at: http://www.medicare.gov/MPPF/Include/DataSection/OOPC/OOPCCalculations.asp?language=English.

MAOs have access to CY 2011 OOPC estimates for each of their current plans and can view those OOPC values in HPMS. Part C OOPCs can be viewed in HPMS under: Quality and Performance > Part C Performance Metrics > Part C Out-of-Pocket Costs. On or about April 8, 2011, an OOPC model will be available in SAS software from the CMS website. All documentation and instructions associated with running the OOPC model will be posted on the CMS website on the following page: http://www.cms.gov/PrescriptionDrugCovGenIn/01_Overview.asp#TopOfPage. Organizations can use this information to develop CY 2012 plan bids that comply with CMS requirements.

In response to comments on the February 18, 2011 Advance Notice and Call Letter, CMS will retain for CY 2012 the $20 meaningful difference threshold required in CY 2011. We determined that doing so will help to ensure that plans' initial bids meet the meaningful difference criteria and may help to minimize plans' bid development challenges as they structure plan benefit packages that also satisfy other CMS requirements. Thus, for CY 2012, CMS will evaluate meaningful differences among non-employer plans offered by the same MAO, in the same county, as follows:

1. Non-SNP plan offerings will be separated into five plan-type groups on a county basis: (1) HMO (2) HMOPOS; (3) Local PPO; (4) Regional PPO; and (5) PFFS. SNP plans will be further separated into groups representing the specific target populations served by the SNP. Chronic Care SNPs will be separated by the chronic disease served, and Institutional SNPs will be separated into the following three categories: Institutional (Facility); Institutional Equivalent (Living in the Community); and a combination of Institutional and Institutional Equivalent. D-SNPs are excluded from the meaningful difference evaluation. Please note that using different providers or serving different ethnic populations are not considered meaningfully different characteristics between two plans.

2. Plans within each plan-type group will be further divided into MA-only and MA-PD sub-groups for evaluation. That is, the presence or absence of a Part D benefit is considered a meaningful difference.
3. The combined Part C and Part D OOPC estimate will be calculated for each plan within the plan-type groups and sorted from high to low. There must be a total OOPC difference of at least $20 per member per month between each plan to be considered meaningfully different.

(Note: Employer plans are not included in this evaluation for CY 2012.)

CMS expects MAOs to submit CY 2012 plan bids that meet the meaningful difference requirements but will not prescribe how the MAOs should redesign benefits packages to achieve the differences. Since MAOs have access to the necessary tools to calculate OOPC estimates for each plan prior to bid submission, CMS may not permit revised submissions if a plan's initial bid does not comply with meaningful difference requirements. Ultimately, plan bids that do not meet these requirements will not be approved by CMS. MAOs are to follow the CY 2012 renewal/non-renewal guidance in this Call Letter to determine if their plans may be consolidated with other plans.

CY 2012 Cost Sharing Standards

A. Maximum Out-of-Pocket (MOOP) Limits

CMS strives to ensure that MAOs develop more transparent plan benefit designs so that beneficiaries are better able to predict their out-of-pocket costs and also are protected from excessively high or unexpected cost sharing. As provided at 42 CFR § 422.100(f)(4), all local MA plans (employer and non-employer), including HMOs, HMOPOS, local PPO (LPPO) plans, special needs plans (SNPs) (including Dual-eligible SNPs), and PFFS plans must establish an annual MOOP limit on total enrollee cost sharing liability for Parts A and B services, the dollar amount of which will be set annually by CMS. In addition, as provided at 42 CFR §§ 422.100(f)(5) and 422.101(d)(3) LPPO and RPPO plans, respectively, are required to have a "catastrophic" limit inclusive of both in- and out-of-network cost sharing for all Parts A and B services, the dollar amount of which also will be set annually by CMS. All cost sharing (i.e., deductibles, coinsurance, and copayments) for Parts A and B services must be included in plans' MOOPs. The "catastrophic" maximum out-of-pocket limit is the term used in regulation (§ 422.100(f)(5)) and is synonymous with "combined" maximum out-of-pocket limit used in the PBP and beneficiary marketing materials.

For CY 2012, we do not want to eliminate incentives for organizations to establish lower voluntary MOOP thresholds. Therefore, we will continue to allow MAOs the option of adopting lower, voluntary MOOP limits. MAOs that adopt voluntary MOOP amounts will have more

flexibility in establishing cost-sharing amounts for Parts A and B services than those that do not elect the voluntary MOOP.

Like all other local MA plans, D-SNPs must establish a MOOP limit to provide this enrollee protection even though the State Medicaid program is usually paying those costs on the enrollee's behalf. Enrollees' eligibility for Medicaid may change during the year, leaving the enrollee liable for cost sharing. We strongly encourage D-SNPs to establish MOOP amounts that are greater than $0 to protect the plan from full liability for the cost sharing amounts in the event that an enrollee's Medicaid coverage is discontinued for some period of time. However, adoption of a $0 MOOP is permitted.

Second, although it may be rare that an enrollee of a D-SNP would be responsible for paying any cost sharing because the State Medicaid program is making those payments on his behalf, the PBPs for D-SNPs must reflect the plan's actual out-of-pocket cost sharing charges for covered services as well as a valid MOOP amount. Additionally, the plan must track each enrollee's cost sharing expenditures. The PBP will not be acceptable without entry of a valid MOOP amount.

For purposes of tracking out-of-pocket spending relative to its MOOP limit, a D-SNP must count only the enrollee's actual out-of-pocket spending. Thus, for any D-SNP enrollee, MA plans must count only those amounts the individual enrollee is responsible for paying net of any State responsibility or exemption from cost sharing toward the MOOP limit rather than the cost-sharing amounts for services the plan has established in its plan benefit package. Effectively, this means that D-SNP enrollees who are not responsible for paying the Medicare Parts A and B cost sharing will rarely reach the MOOP limit.

Since implementation of the Medicare Modernization Act of 2003, RPPOs have been required to establish a MOOP for in-network cost sharing and a catastrophic limit inclusive of both in- and out-of-network cost sharing for Parts A and B services, but had the discretion to set those amounts. For CY 2011, we encouraged RPPOs to adopt either the mandatory or voluntary MOOPs established by CMS.

We proposed in our November 22, 2010 Notice of Proposed Rulemaking (75 FR 71233) to require RPPOs to establish MOOP amounts that are consistent with the limits established each year by CMS. If this proposal is finalized RPPOs would be required to establish both in-network and combined in- and out-of-network (catastrophic) MOOP limits like LPPOs for CY 2012 consistent with the voluntary and mandatory MOOP levels established by CMS for all Parts A and B covered services.

The dollar amounts for the **mandatory, voluntary** and **catastrophic** MOOPs will be set annually by CMS.

Mandatory MOOP The amount CMS sets as the highest limit for enrolled beneficiary in-network cost sharing for Parts A and B services for the contract year.

Voluntary MOOP An amount lower than the CMS established mandatory MOOP. Plans may voluntarily adopt this limit or a lower amount in exchange for increased flexibility in establishing cost sharing amounts for Parts A and B services.

Catastrophic MOOP The amount CMS sets as the highest limit charged by LPPOs and if our proposed rule is finalized, beginning CY 2013 by RPPOs, for the combined in-and out-of-network cost sharing for Parts A and B services for the contract year. The catastrophic MOOP amount is calculated as 1.5 times the mandatory or voluntary MOOP amount, as applicable to the plan.

Plans are responsible for tracking enrolled beneficiaries' out-of-pocket spending and to alert them and plan providers when the spending limit is reached. As stated above, D-SNPs also must track enrollee cost sharing but should include only those amounts the enrollee is responsible for paying net of any State responsibility or exemption from cost sharing.

The chart below provides the CY 2012 mandatory MOOP amount that MA plans may not exceed, the maximum voluntary MOOP amount that, if adopted, would result in less scrutiny of individual service category cost sharing, and the catastrophic MOOP amounts applicable to LPPOs and RPPOs.

CY 2012 Voluntary and Mandatory MOOP Amounts By Plan Type

Plan Type	Voluntary	Mandatory
HMO	$3,400	$6,700
HMO POS	$3,400 In-network	$6,700 In-network
Local PPO	$3,400 In-network and $5,100 Catastrophic*	$6,700 In-network and $10,000 Catastrophic*
Regional PPO**	$3,400 In-network and $5,100 Catastrophic*	$6,700 In-network and $10,000 Catastrophic*
PFFS (full network)	$3,400 In- and out-of-network	$6,700 In- and out-of-network
PFFS (partial network)	$3,400 In- and out-of-network	$6,700 In- and out-of-network
PFFS (non-network)	$3,400	$6,700

*Catastrophic MOOP is inclusive of in- and out-of-network Parts A and B services.

** If our proposal to require RPPOs to offer MOOP amounts consistent with those required for LPPOs, the amounts shown apply for CY 2012.

The MA MOOP amounts are based on a beneficiary-level distribution of Parts A and B cost sharing for individuals enrolled in Original Medicare. The mandatory MOOP amount represents approximately the 95th percentile of projected beneficiary out-of-pocket spending for CY 2012. Stated differently, 5 percent of Original Medicare beneficiaries are expected to incur $6,700 or more in Parts A and B deductibles, copayments and coinsurance in CY 2012. The CY 2012 voluntary MOOP amount will be $3,400. This level was established for CY 2012 because, consistent with established methodology, it represents approximately the 85th percentile of projected Original Medicare out-of-pocket costs.

We determined the catastrophic MOOP amounts applicable to LPPOs and proposed for RPPOs, by multiplying the respective MOOP amounts by 1.5 for the relevant year. Thus, the voluntary catastrophic MOOP amount for CY 2012 is calculated as $3,400 x 1.5 = $5,100. Similarly, the mandatory catastrophic MOOP amount for CY 2012 is calculated as $6,700 x 1.5 = $10,000 (with rounding).

For further discussion on MOOP and how it is shown in D-SNPs' Summary of Benefits (SB), please refer to the section entitled "Changes to 2012 Summary of Benefits Regarding Dual Eligible SNP Cost Sharing" on page 135 of this Call Letter.

B. Total Beneficiary Cost (TBC)

CMS will again exercise its authority under section 1854(a)(5)(C)(ii) of the Affordable Care Act to deny bids, on a case by case basis, if it determines that the bid proposes too significant an increase in cost sharing or decrease in benefits from one plan year to the next. We note that we proposed to codify this authority in our November 22, 2010 proposed rule (75 FR 71200-71201) and may provide further guidance following the finalization of that rule.

For CY 2011, CMS established the Total Beneficiary Cost (TBC) metric as a means of evaluating changes in plan benefits from one year to the next, and whether such changes imposed significant increases in cost-sharing or decreases in benefits. TBC is the sum of plan-specific premium and estimated beneficiary out-of-pocket costs. The change in TBC from one year to the next captures the combined financial impact of premium changes and benefit design changes (i.e., cost-sharing changes) on plan enrollees; an increase in TBC is indicative of a reduction in benefits. Note that, for CY 2012, the TBC calculation will include a factor to account for the Part B premium buy-down for those plans that include this additional benefit as part of their benefit package. By limiting excessive increases in the TBC from one year to the next, CMS is able to ensure that beneficiaries who continue enrollment in the same plan are not exposed to significant cost increases from one plan year to the next.

In implementing this approach for CY 2011, we conducted an outlier analysis after bids were submitted, and negotiated with MA organizations about those MA plans that were identified in that analysis as outliers. In the February 18, 2011 Advance Notice and Call letter we solicited comments as to whether we should again analyze the distribution of TBC changes after bid submission and identify outliers, or instead use historical data to identify a TBC change amount in advance and further scrutinize only those bids whose TBC is above the established TBC amount. Under this second approach, we proposed to set the TBC change amount at approximately $36 PMPM (or about a 10% increase) from CY 2011 to CY 2012. We noted that we reserved the ability to adjust this amount following bid submission if the distribution of all bids increase program costs more than anticipated.

We also noted that, under either approach, plans would be required to apply a plan specific adjustment factor to account for geographic and quality bonus payment related changes in each plan's payment rates. This adjustment is needed to return the TBC to the "level playing field" that existed for CY 2011, when plan payment rates were frozen. This adjustment factor would be derived from the projected change in rebate amount from CY 2011 to CY 2012 for a plan's CY 2011 service area, and CMS would provide this factor to each plan shortly after release of the final call letter.

We received many comments, all of which expressed a preference for the second option under which a TBC amount would be provided in advance of the date bids are due, and many asked

that CMS take into consideration the differences in payment rates, the new quality bonus payments, and changes to the rebate percentages by geographic area. Therefore, we plan to implement the second approach for non-employer plans (excluding D-SNPs) as modified in response to these latter comments, and will calculate and provide to each plan an amount that reflects the impact of payment changes and any quality bonus payments for which the plan is eligible. Each plan-specific amount will be an effective TBC limit for that plan. Thus, plans experiencing a net increase in benchmarks/bonus payments will have an effective TBC change amount below the 10% (or $36) amount. Conversely, plans experiencing a net decrease in benchmark and/or bonus payments will have an effective TBC change amount above the 10% (or $36) amount. Based on this analysis, CMS will not deny a bid solely on the grounds that TBC has increased by too much from CY 2011 to CY 2012 if the increase is equal to or less than the plan-specific TBC amount. However, plans whose TBC increases are above their plan-specific amounts would be subject to further scrutiny by CMS, and could be denied. We believe this approach will protect beneficiaries from significant increases in cost sharing or decreases in benefits, while ensuring access to viable and sustainable MA plan offerings. We also note that CMS reserves the right to further examine and to request additional changes to a plan bid, even if its TBC change is within the plan-specific TBC change amount, if we find it is in the best interest of the MA program.

For plans that consolidate multiple CY 2011 plans into a single CY 2012 plan, CMS will use the enrollment-weighted average of the CY 2011 plan values to calculate TBC. Otherwise, these plans will be treated as any other plan for the purpose of enforcing the TBC requirement.

C. Discriminatory Cost Sharing Assessments

For CY 2012, CMS has established three benefit discrimination assessments for all MA plans (employer and non-employer):

1. Per Member Per Month (PMPM) Actuarially Equivalent (AE) Cost Sharing Maximums;
2. Service Category Cost Sharing Standards; and
3. Discriminatory Pattern Analysis.

The PMPM actuarial equivalent cost sharing maximums and service category cost sharing standards described below are provided in advance of the bid submission deadline with the expectation that all CY 2012 plan bids will conform to these standards when submitted on or before June 6, 2011. CMS will perform a discriminatory pattern analysis following bid submission to identify and resolve discriminatory benefit design elements not anticipated by the standards.

Please note that benefit design and cost sharing amounts approved for CY 2011 will not be automatically acceptable for CY 2012 because a separate and distinct review is conducted each contract year.

1. Per Member Per Month (PMPM) Actuarial Equivalent (AE) Cost Sharing Maximums

Total MA cost sharing for Parts A and B services must not exceed cost sharing for those services in Original Medicare on an actuarially equivalent basis. CMS will also apply this requirement separately to the following service categories for CY 2012: Inpatient Facility, Skilled Nursing Facility (SNF), Home Health, Durable Medical Equipment (DME), and Part B drugs.

Whether in the aggregate, or on a service-specific basis, excess cost sharing is identified by comparing two values found in Worksheet 4 of the Bid Pricing Tool (BPT).

Specifically, a plan's PMPM cost sharing for Medicare covered services (BPT Worksheet 4, Section IIA, column l) is compared to Original Medicare actuarially equivalent cost sharing (BPT Worksheet 4, Section IIA, column n). For inpatient facility and SNF services, the AE Original Medicare cost sharing values, unlike plan cost sharing values, do not include Part B cost sharing; therefore, an adjustment factor is applied to these AE Original Medicare values to incorporate Part B cost sharing and to make the comparison valid.

Once the comparison amounts have been determined, excess cost sharing can be identified. Excess cost sharing is the difference (if positive) between the plan cost sharing amount (column #1) and the comparison amount (column #5). The chart below uses illustrative values to demonstrate the mechanics of this determination.

Illustrative Comparison of Service-Level Actuarial Equivalent Costs to Identify Excessive Cost Sharing

	#1	#2	#3	#4	#5	#6	#7
BPT Benefit Category	PMPM Plan Cost Sharing (Parts A&B) *(BPT Col. l)*	Original Medicare Allowed *(BPT Col. m)*	Original Medicare AE Cost sharing (Part A only) *(BPT Col. n)*	Part B Adjustment. Factor to Incorporate Part B Cost Sharing (Based on FFS data)	Comparison Amount *(#3 × #4)*	Excess Cost Sharing (#1 − #5)	Pass/ Fail
Inpatient	$33.49	$331.06	$25.30	1.366	$34.56	$0.00	Pass
SNF	$10.83	$58.19	$9.89	1.073	$10.61	$0.22	Fail
Home Health*	TBD	TBD	TBD	TBD	TBD	TBD	Pass
DME	$3.00	$11.37	$2.65	1.000	$2.65	$0.35	Fail
Part B-Rx	$0.06	$1.42	$0.33	1.000	$0.33	$0.00	Pass

* Home health has no cost sharing under Original Medicare, so the comparison amount (#5) is calculated by multiplying the Medicare allowed amount (#2) by the Part B Adjustment Factor (#4).

2. Service Category Cost Sharing Standards

As provided under 42 CFR § 422.100(f)(6), we may specify service categories for which the cost sharing charged by MA plans may not exceed levels annually determined by CMS to be discriminatory. For purposes of setting cost sharing thresholds for Parts A and B services, CMS reviews the prior year's bid data, as well as actuarial equivalency relative to Original Medicare, in order to identify cost sharing requirements.

Similar to last year, CMS is focusing these standards on those Parts A and B services that are more likely to have a discriminatory impact on sicker beneficiaries. The standards are based on a combination of patient utilization scenarios and Original Medicare. The scenarios reflect factors such as hospital lengths of stay and the number of physician office visits generated by average-to-sicker patients. Some service categories have multiple utilization scenarios in an effort to ensure that plans will consistently distribute cost sharing amounts in a manner that does not discriminate.

We are continuing our current policy of offering MA plans the option to have greater flexibility in establishing Parts A and B cost sharing than is available for plans that adopt the mandatory MOOP by adopting a lower voluntary MOOP limit.

The chart below summarizes the standards and cost sharing amounts by MOOP type (e.g., mandatory or voluntary) for local and regional MA plans. CY 2012 plan bids must reflect enrollee cost sharing for in-network services that is not greater than the amounts displayed below. For LPPOs and RPPOs, these standards will be applied only to in-network services. All standards are inclusive of applicable service category deductibles, copayments and coinsurance, but do not include plan level deductibles.

CY 2012 In-Network Service Category Cost Sharing Requirements

Cost Sharing Limits			
Service Category	**PBP Section B data entry field**	**Voluntary MOOP**	**Mandatory MOOP**
Inpatient - 60 days	1a	N/A	$3,935
Inpatient - 10 days	1a	$2,231	$1,785
Inpatient - 6 days	1a	$2,016	$1,613
Mental Health Inpatient - 60 days	1b	$2,471	$1,977
Mental Health Inpatient - 15 days	1b	$1,796	$1,437
Skilled Nursing Facility – First 20 Days[1]	2a	$100/day	$50/day
Skilled Nursing Facility – Days 21 through 100[1]	2a	$146/day	$146/day
Home Health	6a	TBD	$0
Primary Care Physician	7a	$35 co-pay	$35 co-pay
Chiropractic Care	7b	$20 co-pay	$20 co-pay
Physician Specialist	7d	$50 co-pay	$50 co-pay
Psychiatric Services	7e and 7h	$40 co-pay	$40 co-pay
Therapeutic Radiological Services	8b	20% or $60 co-pay	20% or $60 co-pay
DME-Equipment	11a	N/A	20%
DME-Prosthetics	11b	N/A	20%
DME-Medical Supplies	11b	N/A	20%
DME-Diabetes Monitoring Supplies	11c	N/A	20% or $10 co-pay
DME-Diabetic Shoes or Inserts	11c	N/A	20% or $10 copay
Renal Dialysis	12	20% or $30 co-pay	20% or $30 co-pay
Part B Drugs-Chemotherapy[2]	15	20% or $75 co-pay	20% or $75 co-pay
Part B Drugs-Other	15	20% or $50 co-pay	20% or $50 co-pay

1. MA plans may have cost sharing for the first 20 days of a SNF stay, consistent with cost sharing guidance. The per-day cost sharing for days 21 through 100 must not be greater than the Original Medicare SNF amount. Total cost sharing for the overall SNF benefit must be actuarially equivalent with Original Medicare.
2. Home health cost sharing policy for CY 2012 will be determined in the current notice and comment rulemaking process (75 FR 71190)
3. Chemotherapy includes administration services. Chemotherapy drugs and administration services in an inpatient setting are covered under the MA plan's inpatient benefit coverage.

3. Discriminatory Pattern Analysis

Following CY 2012 plan bid submissions, CMS will ensure that MA plans conform to the cost sharing requirements. In addition, CMS will analyze bids to ensure that discriminatory benefit designs are identified and corrected. This could include bids that meet standards but have cost

sharing amounts that are distributed in a manner that may discriminate against sicker, higher-cost patients. This analysis may also evaluate the impact of benefit design on patient health status and/or certain disease states. CMS will contact plans to discuss and correct any issues that are identified as a result these analyses.

Other Cost Sharing Policy Issues

A. Multi-Year Benefits

In the February 18, 2011 Advance Notice and Call Letter we shared our concern that allowing MA plans and section 1876 cost contract plans to offer benefits and cost sharing that span multiple contract years, multi-year benefits, is inconsistent with its goal to provide beneficiaries with plan choices that are easy to understand. We expressed our beliefs that a benefit that spans multiple contract years is confusing to many enrolled beneficiaries because it requires them to keep track of which services have been received and which are unused, across years and that multi-year benefits complicate the comparison of plans by beneficiaries during the open enrollment periods. We proposed to make no change to policy for CY 2012 but we encouraged plans to limit CY 2012 benefit offerings to one contract year in order to minimize the potential for beneficiary confusion.

We received many comments on this topic expressing both support for discontinuation of multi-year benefit offerings and opposition to such a policy. Many of the commenters stated that some benefits are more appropriately offered over a multi-year period and that plans would be unable to afford to offer some benefits at all (e.g., denture and eyewear coverage) if they are not permitted to offer the benefit over more than one year. The commenters who were in favor of limiting plans' benefit offerings to one contract year stated that they shared CMS' concerns about beneficiaries being able to compare plans when some offer multi-year benefits and enrollees being able to keep track of their benefits while in the plan. These commenters also stated their belief that having benefits that span contract years can act as a disincentive for beneficiaries to actively compare plans annually and make choices that meet their needs.

We understand that some benefits are appropriately offered over multiple years, but continue to encourage plans to limit offerings to one contract year where possible.

B. Copayment and Coinsurance for the Same Service

We have found that, as is allowed for PBP data entry, a small number of plans enter both coinsurance and copayment amounts for the same service categories, presumably to capture variation in the plan's contracting agreements. We want to enable plans to accurately reflect their benefit packages in the PBP but also are committed to ensuring that plan benefits and cost sharing are easily understood by beneficiaries and that an enrollee is not charged both a

coinsurance and a copayment for the same service. In our work to revise the PBP for CY 2012, we performed analyses to see how often plans were entering both coinsurance and copayment amounts for the same service categories. We were pleased to find that very few plans entered both types of cost sharing values for any service category in the CY 2011 bids and determined that we would be interested in simplifying the PBP by enabling plans to enter only one type of cost sharing for each of the service categories.

We received many comments on this topic both from commenters who share CMS' concerns about permitting both types of cost sharing for the same service category and from those that assert that there is a legitimate need to maintain that capability in the PBP. They explained that the PBP needs to accept both types of cost sharing in some service categories because, as plans contract with various providers, they must have the flexibility to agree to copayment arrangements with some and coinsurance arrangements with others.

Therefore, for CY 2012, we continue to discourage plans from entering both types of cost sharing for any service category, but will not disallow those entries because we understand that, as reflected in the comments, to offer enrollees the most effective network of providers, plans need the flexibility to contract with different service settings (for example, freestanding imaging center, hospital outpatient department) to furnish services within a service category and they may require varying cost sharing arrangements. Plans must make those differences in cost sharing transparent to beneficiaries through the ANOC, EOC, SB sentences and marketing materials and ensure that enrollees are not charged twice for the same service.

C. PBP Notes

CMS' longstanding policy requires that the Notes sections in the PBP may be used to provide additional information about the benefit that is being offered. The information in the note must not contain any cost sharing for the benefit/service that is not reflected in the PBP data entry field for the benefit/service. Any information in a note must be consistent with the benefit/service as it is reflected in the PBP data entry fields. The Notes must not be used to enter additional benefits, conditions for coverage or cost sharing charges because that information is not captured to generate summary of benefits (SB) sentences that would make it available to beneficiaries. All cost sharing must be transparent and readily accessible to beneficiaries as they make plan comparisons. Plans may request hard copy SB changes that can be used to relay to beneficiaries more detailed, additional information about the benefit offered.

We received a number of comments on this topic urging CMS to make the PBP more flexible to enable entry of more complex cost sharing arrangements. The commenters stated that plans are currently unable to enter all of their cost sharing arrangements in the PBP and sometimes must use the notes to reflect required cost sharing, especially for out-of-network services.

We thank the commenters for sharing their opinions with us. We have already completed the revisions to the PBP for the upcoming CY 2012 bid submissions and can make no further revisions at this time, but, as we move forward with revisions to the PBP for CY 2013, we will make every effort to ensure that it accommodates plans' entries for any acceptable cost sharing strategies.

D. Supplemental Benefits for Section 1876 Cost Plans

Although cost contracts are prohibited from offering mandatory supplemental benefits, CMS has permitted cost contracts to include collections of optional supplemental benefits in addition to their basic Parts A and B benefits as separate plan benefit package (PBPs) in order to indicate to potential enrollees in Medicare Plan Finder and Medicare & You that optional supplemental benefits are available. CMS does not, however, consider such collections of optional supplemental benefits as separate plan benefit packages, and cost contracts cannot require that potential enrollees choose one of the collections of supplemental benefits in order to enroll. If a cost contract wishes to discontinue a package of optional supplemental benefits for a subsequent contract year, CMS does not consider this a termination of a PBP. Any cost optional supplemental package marked as "terminated" for Contract Year (CY) 2012 will be required to be crosswalked via the plan crosswalk to another supplemental package offered by the cost contract. Cost contracts in this situation must transition enrollees to the cost contract's basic Parts A and B package – with or without Part D depending on the enrollee's original election – via the HPMS Plan Crosswalk. Additional detail on this issue is provided in the renewal/non-renewal guidance in this Call Letter.

Changes to 2012 Summary of Benefits Regarding Dual Eligible SNP Cost Sharing

CMS is changing the structure of the Summary of Benefits (SB) to address an issue related to how the Maximum Out-of-Pocket (MOOP) limit is reflected for D-SNP enrollees. For contract year 2010, CMS added a new requirement in the bid submission, whereby plans were required to have a MOOP limit in their bids, resulting in a MOOP value appearing in the SB (in column 3 under the plan benefit information).

For contract year 2011, CMS provided a temporary solution by allowing plans to submit a hard copy change to add qualifying language via an asterisk, indicating that the amount beneficiaries may have to pay is based on their level of state Medicaid assistance.

For contract year 2012, CMS is making programming changes to the SB sentences to ensure that cost sharing amounts are displayed accurately.

Renewal Material Timelines Given AEP Changes

Due to the statutory changes to the Annual Enrollment Period (AEP), the CY 2012 standardized, combined Annual Notice of Change (ANOC)/Evidence of Coverage (EOC) documents are due to current members of all MA plans, MA-PD plans, PDPs, and cost-based plans offering Part D by September 30, 2011. Organizations are not required to mail the Summary of Benefits (SB) to existing members when using the combined, standardized ANOC/EOC; however the SB must be available upon request.

In addition to the ANOC/EOC documents, organizations must provide the LIS rider and formulary, if applicable, to enrollees for receipt by September 30, 2011. Plan sponsors should note that no other materials regarding 2011 plan offerings may be sent prior to the beginning of marketing activities on October 1, 2011.

CMS received numerous comments on the short timeframes available for plans to meet the September 30 mailing date of the ANOC/EOC and LIS rider as well as requests to move up the marketing start date to September 1 instead of October 1. We believe that the new schedule – with marketing beginning on October 1, and the AEP beginning 15 days later – actually reduces confusion for beneficiaries and plans, and are therefore retaining the October 1 start date. In prior years, plans were able to begin marketing well in advance of the AEP, but beneficiaries could not submit enrollment requests until the AEP began on November 15. Beneficiaries were often confused by this discrepancy and submitted enrollment forms in advance of the AEP, which the organization then had to "hold" until November 15. While we realize that plans will have less time to market prior to the start of the AEP, they will be able to continue marketing throughout the AEP, and beneficiaries will receive information from CMS (via the Medicare Handbook, by contacting 1-800-MEDICARE) throughout that time, and will be able to obtain the information they need to make an informed choice by the time the AEP ends on December 7.

III. Part D

Generic Samples Paid for Through Part D Sponsors' Administrative Costs

As described in section 60.2 of Chapter 7 of the Prescription Drug Benefit Manual, CMS allows Part D sponsors the option to provide OTCs as part of their administrative cost structure when a component of a cost-effective drug utilization management program and without any cost sharing on the part of the beneficiary at the point-of-sale. We have been asked whether the provision of generic samples in physician offices could be similarly treated under Part D and are now providing this guidance, effective immediately. Sponsors may incur expenses related to distribution of and reporting on generic drug samples, provided to members within a physician's office setting, under the plan's administrative cost structure if doing so is consistent with a cost effective drug utilization management program. Any provision of generic samples must be conducted consistent with the requirements of the Prescription Drug Marketing Act, 21 USC

§353 and the Food and Drug Administration's implementing regulations at 21 CFR Part 203. A drug sample, as defined by 21 CFR §203.3(i), means a unit of a prescription drug that is not intended to be sold and is intended to promote the sale of the drug. To clarify, for purposes of this analysis, a generic drug sample is a "unit of a prescription drug, limited to a drug subject to an application approved under section 505(j) of the Federal Food, Drug, and Cosmetic Act, which is not intended to be sold and is intended to promote the sale of the drug." A brand drug sample is "a unit of a prescription drug, limited to a drug subject to an application approved under section 505(c) of the Federal Food, Drug, and Cosmetic Act, which is not intended to be sold and is intended to promote the sale of the drug." Drug samples do not meet the definition of a covered Part D drug under 42 CFR §423.100 because they are not dispensed at a network pharmacy nor are they consistent with our out-of-network pharmacy coverage requirements stated at 42 CFR § 423.124. In other words, drug samples do not meet the emergency definition (42 CFR §124 (a)(1)) and do not represent Part D drugs, unlike vaccines, which are appropriately dispensed and administered by physicians (42 CFR §124 (a)(2)).

Given that generic samples do not meet the definition of a Part D drug, Part D sponsors cannot include the provision of samples as part of their benefit structure. Thus, such samples would not be placed on formulary tiers, and like similarly treated OTC products, such samples must be provided to enrollees without cost sharing requirements. However, in contrast to our related policy on the use of OTC products as part of a utilization management program (See Prescription Drug Manual, Chapter 7, Section 60.2), generic samples may not be incorporated into step-therapy protocols because all enrollees would not have equal access to such samples. More broadly, Part D sponsors may not require beneficiaries to use generic samples under any conditions. CMS recognizes that generic drug samples may be an effective utilization management tool used to promote compliance with a new drug therapy. By facilitating access to trial supplies of less costly generic versions of Part D drugs, plan sponsors can enhance their enrollees' experience in Part D by reducing their current and future cost sharing expenses. In the case of low income subsidy entitled beneficiaries, facilitating medication starts on generic versions of drugs also helps to limit federal low income cost sharing subsidy reimbursements and overall program costs to the Trust Fund. Therefore, we believe that Part D sponsors may contract with vendors to provide access to and reporting on generic drug samples as part of their drug utilization management program as an incentive to reduce drug costs by promoting the use of lower cost generic medications (We expect that Part D sponsors will have the appropriate business associate agreements with the vendors providing generic sample to Part D beneficiaries. The business associate agreement should require that a beneficiary's protected health information only be used for transactions directly related to providing a generic sample to the Part D beneficiary and reporting the beneficiary's receipt of a generic sample to the Part D sponsor).

If desirable, Part D sponsors should account for such costs when developing their 2012 bids, but may also contract for such services in 2011 if they determine that doing so under their utilization

management programs would be an offset to their prescription drug costs. CMS currently has no plans to require reporting on generic samples provided to Part D beneficiaries through PDE reporting, or otherwise.

In making this clarification, we specifically distinguish generic samples from brand samples. We believe that the provision of brand name drug samples would not be an appropriate use of administrative costs and would not be consistent with the requirements relating to drug utilization management at 42 CFR §423.153(b), which direct Part D sponsors to establish a drug utilization management program that includes incentives to reduce costs when medically appropriate.

Applying Best Available Evidence Policy to Beneficiaries of Home and Community Based Waiver Services

Section 3309 of the Affordable Care Act (the ACA) eliminates Part D cost sharing for full-benefit dual-eligible individuals who would be institutionalized individuals, if they were not receiving home- and community-based services (HCBS) under Title XIX of the Act.

The elimination of Part D cost sharing applies to all full-benefit dual-eligible individuals receiving HCBS under an HCBS waiver authorized for a State under section 1115 of the Act, subsections (c) or (d) of section 1915 of the Act, under a State plan amendment under subsection (i) of such section, or services provided through enrollment in a Medicaid managed care organization with a contract under section 1903(m) or section 1932 of the Act. HCBS eligibility is not based on where an individual resides. In other words, sponsors cannot assume that all beneficiaries residing in assisted living facilities receive HCBS and therefore qualify for the $0 cost sharing. Thus, in order to receive the waiver under Section 3309, a plan sponsor must determine or a beneficiary must demonstrate that s/he is a full-benefit dual-eligible Individual receiving HCBS under Title XIX. This provision will be implemented effective January 1, 2012.

Section 70.5 of Chapter 13 in the Medicare Managed Care manual already includes a list of acceptable documents that may be used to demonstrate Medicaid eligibility, if a beneficiary is not already in CMS' data systems as a full-benefit dual-eligible. We will be updating Chapter 13 to also include a list of acceptable documents that may be used as best available evidence (BAE) for demonstrating receipt of HCBS, such as:

a) A copy of a State-issued Notice of Action, Notice of Determination, or Notice of Enrollment that includes the beneficiary's name and HCBS eligibility date during a month after June of the previous calendar year;
b) A copy of a State-approved HCBS Service Plan that includes the beneficiary's name and effective date beginning during a month after June of the previous calendar year;

c) A copy of a State-issued prior authorization approval letter for HCBS that includes the beneficiary's name and effective date beginning during a month after June of the previous calendar year; or
d) Other documentation provided by the State showing HCBS eligibility status during a month after June of the previous calendar year.

We are committed to working closely with states to clarify the contents of the state file submissions and the BAE policy for HCBS. The data that CMS receives from the states identifying full-benefit dual-eligible individuals receiving HCBS will generate copay level 3 ($0) for these individuals, effective January 1, 2012. Plan sponsors must use this information to update their own systems as necessary to reflect $0 Part D cost sharing for their qualified Part D enrollees.

Monitoring the Implementation of Transition Policy

In CY 2011 CMS required Part D sponsors to complete transition attestations in HPMS and submit a transition policy and implementation statements through the CMS Part D transition mailbox. The CY 2011 review revealed many polices were deficient and did not adequately address all attestations. CMS spent a significant amount of time reviewing updated policies and providing technical assistance and guidance to Part D sponsors to bring the policies into compliance with the regulatory requirements. Despite CMS' efforts to work with plans to achieve approvable transition policies, subsequent audits revealed that Part D sponsors were not implementing the transition policies appropriately in their claims adjudication systems. Therefore, beneficiaries were not receiving their required transition supplies, which is a basic protection of the Part D program to ensure continuity of care. On August 27, 2010, CMS issued an HPMS memo to provide additional clarification to Part D sponsors on the transition benefit.

As a result of the audit findings, CMS remains concerned with whether Part D sponsors are appropriately implementing the transition policy. CMS is exploring several methods to determine if Part D sponsors are implementing their transition policy consistent with CMS' guidance and applicable regulations. CMS will require that Part D sponsors provide documentation that their transition policy is correctly implemented in their claims system and that beneficiaries are receiving their required transition supplies. This documentation may require the sponsor to submit any or all of the following: (1) up to one quarter's worth of denied claims for 2012; (2) test claims for new beneficiaries; (3) identification of new beneficiaries and documentation of paid claims for transition supplies; or (4) evidence of transition supplies provided across contract years.

Medication Therapy Management (MTM) Services and Racial Disparities

In August 2010, Health Services Research (HSR), an organization that publishes findings from investigations in the field of health care to help improve the health of individuals and communities, published findings from a research study under the title "Disparity Implications of Medicare Eligibility Criteria for Medication Therapy Management Services." (Wang et al. 2010. "Disparity Implications of Medicare Eligibility Criteria for Medication Therapy Management Services." *Health Services Research 45 (4*): 1061-1082.) The objective of the research study was to determine if there were racial and ethnic disparities in meeting eligibility criteria for MTM services provided for Medicare Part D beneficiaries. The report findings suggest that Hispanic and African American beneficiaries could have a lower likelihood of meeting the MTM eligibility criteria when compared to whites based on the original MTM eligibility thresholds in 2006 and the new thresholds beginning in 2010. The study also found that there was disparity among beneficiaries with severe health problems. There are important implications for the Part D program considering these findings are consistent with other literature which suggests that minorities have lower utilization of drugs and health services in general, and the MTM eligibility criteria are based on utilization. The Part D benefit requires prescription drug sponsors to establish a MTM program to optimize therapeutic outcomes for targeted beneficiaries who meet high risk criteria, but currently a potentially vulnerable segment of the population may not be targeted accurately to receive MTM services.

CMS is conducting an analysis to verify the report's findings. As a first step of the analysis, CMS is replicating the analysis conducted in the HSR study using a larger sample of beneficiaries and will also investigate potential racial disparities using the plan-reported MTM data which reflects actual experience. If the report findings are validated, CMS may consider changes to the MTM eligibility thresholds in future rulemaking. Sponsors have had flexibility to determine the first two elements that make up the definition of MTM targeted beneficiaries, and CMS has put in place additional restrictions to define these elements beginning in 2010. CMS appreciates the comments sponsors made to the draft Call letter regarding the MTM eligibility criteria that could be used to target individuals who would otherwise receive a disparate level of care. We strongly encourage sponsors to continue to examine their defined MTM targeting criteria and implement or pilot any changes to the criteria as needed to minimize racial disparities in MTM eligibility. We look forward to additional sponsor input as we further evaluate and develop this area of our MTM policies.

Reassignment Policy for 2012

In the fall of 2011, CMS will again reassign auto-enrolled low income subsidy (LIS) beneficiaries who are in a PDP that has a premium at or below the LIS benchmark in 2011, but above the LIS benchmark in 2012, as well as all LIS beneficiaries whose PDP is terminating for 2012. CMS will also reassign beneficiaries who remain LIS-eligible as of January 1, 2012, and

are in Medicare Advantage plans that are terminating in 2012. Consistent with section 3303 of the Affordable Care Act (ACA), PDPs that volunteer to waive a de minimis amount of the premium will no longer lose LIS beneficiaries to reassignment based on the fact that their monthly premium exceeds the low-income benchmark; however, such PDPs will not receive reassignments and auto-enrollments. We anticipate establishing the de minimis amount in August 2011. Details of the reassignment process may be found in section 40.1.5 of the PDP Eligibility, Enrollment, and Disenrollment Guidance, available on our website at: http://www.cms.gov/MedicarePresDrugEligEnrol/Downloads/FINALPDPEnrollmentandDisenrollmentGuidanceUpdateforCY2011.pdf.

Consistent with section 40.1.5 of the enrollment guidance, CMS will first reassign beneficiaries within the same organization if the organization offers another qualified PDP in the same region, either under the same contract number, or if that is not available, under a different contract number sponsored by the same parent organization. If the organization does not offer another qualifying PDP, CMS will randomly reassign affected beneficiaries to other PDP sponsors that have at least one qualifying PDP in that region. CMS will follow the two-step process used for auto-enrollment, i.e., random distribution first at the organization level, then randomly among qualifying PDPs within the organization (see section 40.1.4.C).

Note that organizations under an enrollment sanction will not receive reassignments, either from within their organization or through the random reassignment process. Thus, if a sanctioned organization offers a PDP with a 2011 premium below the low-income benchmark amount and that PDP's premium will be above this threshold for 2012—resulting in premium liability for LIS beneficiaries—affected enrollees in that PDP will be randomly reassigned to other PDPs in the region with a premium at or below the LIS benchmark amount.

Benefit Design

Low Enrollment Plans (Stand-alone PDPs only)

CMS has the authority under to 42 CFR §423.507(b)(1)(iii) to non-renew plans (at the benefit package level) that do not have sufficient number of enrollees to establish that they are viable plan options. Consistent with that authority, we will again be scrutinizing low-enrollment plans during the bid review period and will expect that sponsors will have withdrawn or consolidated low-enrollment plans prior to submitting bids for CY 2012. This guidance applies to non-employer stand-alone Part D plans since CMS previously granted a waiver of 42 CFR §423.512(a) (minimum enrollment requirements) for sponsors of employer group plans. We reserve the right to reconsider this waiver in the future.

CMS intends to notify Part D sponsors in writing in April 2011, concerning the plans the agency considers to be low enrollment plans that may need to be withdrawn or consolidated . We expect

to particularly examine plans that constitute the lowest quintile (20%) per region of 2011 plans ranked by enrollment. As of February 2011, the lowest quintile was comprised of 173 plans, with an average of 5 plans per each of the 34 PDP regions. These plans had a total enrollment of 79,953 beneficiaries, with an average of 462 enrollees and a median enrollment of 273 per plan. The actual plan enrollments ranged from a low of 4 to a high of 2,490 beneficiaries. While we are particularly concerned about the smallest plans, we urge sponsors to consider withdrawing or consolidating any stand-alone plan with less than 1,000 enrollees. Sponsors are strongly encouraged to view data on plan enrollment count at: www.cms.hhs.gov/MCRAdvPartDenrolData/ to determine if any of their plans fall into the lowest quintile.

Before CMS would take any action to non-renew a plan pursuant to 42 CFR §423.507(b)(1)(iii), CMS would take into account all relevant factors, including, but not limited to: (1) whether the plan is a basic plan offered to meet the regulatory requirement in 42 CFR § 423.104(f)(2) that a PDP sponsor may not offer enhanced alternative coverage in a service area unless the sponsor also offers a basic drug plan in the area, in which case CMS would renew the basic plan;(2) whether the plan was a new plan and if it has been in existence for three or more years; (3) whether the plan is offered nationally; (4) the total number of plan offerings in the applicable region; and (5) if the plan's premium currently falls at or below the low income benchmark premium amount.

Meaningful Differences in Part D Coverage

As part of the bid negotiation process, CMS seeks to ensure a proper balance between affording beneficiaries a wide range of plan choices and avoiding undue beneficiary confusion in making coverage selections. Part D regulations require that plan offerings by sponsors represent meaningful differences to beneficiaries with respect to benefit packages and plan cost structures. Pursuant to § 423.272(b)(3)(i), CMS will only approve a bid submitted by a Part D sponsor if its plan benefit package or plan cost structure is substantially different from those of other plan offerings by the sponsor in the service area with respect to key characteristics such as premiums, cost-sharing, formulary structure, or benefits offered. Section 423.265(b)(2) also requires that Part D sponsors' bid submissions in the same service area reflect differences in benefit packages or plan costs that we determine to represent substantial differences from each other.

Again for 2012, CMS will be waiving the meaningful differences requirements of sections 42 CFR 423.272(b)(3)(i) and 423.265(b)(2) to allow sponsors of employer group plans (800 series and direct contract plans) to submit, and seek approval of, employer plan benefit packages that do not meet the meaningful differences requirements. We reserve the right to reconsider this waiver in the future.

As noted last year in the 2011 Part D Plan Benefit Package (PBP) Submission and Review Instructions, CMS does not believe that sponsors can demonstrate meaningful differences based on expected Cost-Sharing Out-of-Pocket Costs (OOPCs) between two stand-alone basic Part D benefit designs and maintain both the statutory actuarial equivalence requirements and fulfill the requirement in §423.153(b) to maintain cost-effective drug utilization review programs. Therefore, sponsors again for the 2012 contract year should submit only 1 basic offering (where basic offering includes defined standard, actuarial equivalent and basic alternative drug benefit types) for a stand-alone prescription drug plan (PDP) in a service area. As in prior years, CMS will negotiate with Part D sponsors to offer no more than 3 stand-alone prescription drug plan offerings in a service area, resulting in a mix of 1 basic and at most, 2 enhanced plans—subject to the following qualifications.

A. Cost-Sharing OOPC Differential Thresholds (Stand-Alone PDPs Only)

To determine if cost sharing and formulary and benefit differences result in meaningful differences for the 2012 Contract Year, CMS expects the Cost-Sharing OOPC differential (exclusive of premium amounts) between a basic benefit offering and an enhanced offering of the same Part D sponsor in the same service area to be at least $22 monthly ($264 annually). In other words, the expected Cost-Sharing OOPCs of the basic plan should be higher by at least $22 monthly than the enhanced offering. This amount has not changed from last year.

CMS will also continue its expectation that where 2 enhanced stand-alone drug plans are offered within the same service area, the second enhanced plan will have a higher value than the first and include coverage of at least some brand drugs in the gap (where "some" is defined as ≥ 10% - 65% of formulary drug entities labeled as brands). In addition, CMS expects that the Cost-Sharing OOPC differential between the two enhanced offerings will be at least $16. In other words, the expected Cost-Sharing OOPCs of the first enhanced offering will be at least $16 higher than the second enhanced offering. Assigning a value to the Cost-Sharing OOPC differential between two enhanced offerings is new this year.

B. Cost-Sharing OOPC Differential Analysis (Stand-Alone PDPs Only)

For the CY 2011 bid submission, CMS used the cost-sharing OOPC amounts in establishing differences between basic and enhanced plans and between low and high value enhanced. Since then, CMS has received questions about our Cost-Sharing OOPC differential analysis. We employ this analysis to establish meaningful differences among basic and enhanced plans across the Part D program, not just between contract offerings. The purpose of the analysis and the setting of the target differential dollar amounts is to ensure that beneficiaries will receive a minimum additional value over basic coverage, and between enhanced coverage offerings, when they select and pay premiums for any enhanced plan. The analysis is not used to evaluate relative levels of all out-of-pocket costs that a beneficiary may incur, but rather, to establish the

difference in cost-sharing incurred among plans as a measure of additional benefits available to the average consumer. For this reason, the analysis is not intended to take plan-level enrollee utilization into account. Similarly, premiums are not included in the calculation because in the case of enhanced plans (as opposed to basic plans), any additional premium exactly offsets the additional benefits, by law. Thus, supplemental premiums cancel out the additional value of the enhanced benefits and do not leave a comparable amount to be compared to the value of basic benefits.

In order to set a value for meaningful differences, CMS must be able to evaluate plan benefit packages (PBPs) on the same yardstick. This is accomplished by running the identical Medicare Current Beneficiary Survey (MCBS) data through each PBP. More specifically, CMS established the targets for differentiation by evaluating expected Cost-Sharing OOPC amounts under each 2011 plan offering by the same sponsor in a service area. For this relative analysis, CMS utilized a uniform market basket of drugs from a representative population of Medicare beneficiaries run through each plan's benefit design. Cost-sharing OOPC estimates were originally calculated using PBP and formulary data available during the 2011 bid review period, but were reevaluated using more recent PBP, formulary, and MCBS data (2005/6) as well as more precise calculations related to additional gap coverage for a subset of drugs on a particular tier or tiers (i.e., partial tier additional gap coverage). The latter calculation includes the MCBS data that will be used for the 2012 OOPC estimates. The chart below depicts a summary of the results of our analysis based on CY 2011 data:

2011 Cost-Sharing OOPC Differential Analysis

August Bid/Formulary Data, 2004/5 MCBS Data						
Plan Comparison	**# of Plans**	**Mean**	**25th**	**50th**	**75th**	**95th**
1st Enhanced Plan vs. Basic Plan	886	-$23.55	-$23.48	-$22.58	-$22.16	-$20.88
2nd Enhanced Plan vs. 1st Enhanced Plan	146	-$15.41	-$16.17	-$16.17	-$13.68	-$13.35
December Bid/Formulary Data, 2005/6 MCBS Data						
Plan Comparison	**# of Plans**	**Mean**	**25th**	**50th**	**75th**	**95th**
1st Enhanced Plan vs. Basic Plan	886	-$27.96	-$32.36	-$28.14	-$25.63	-$17.60
2nd Enhanced Plan vs. 1st Enhanced Plan	146	-$12.29	-$16.25	-$15.93	-$5.78	-$5.78

Using the updated OOPC model with the most current formulary, PBP and MCBS data and a more precise calculation for partial gap coverage, the median monthly difference between basic and enhanced plan offerings increased to nearly $28. However, to maintain consistency in this meaningful differences test while sponsors continue to gain experience calculating OOPC estimates, the minimum monthly threshold value between basic and enhanced plan offerings will remain at $22 for CY 2012. Because the 2011 OOPCs considered partial gap coverage to be the same as full gap, the impact on the partial gap plans was greater as the OOPC differentials decreased further away from the median. This was especially evident in the comparison between enhanced plan offerings (with adjusted OOPC differentials) that were not meaningfully different for these plans. Therefore, for CY 2012, CMS is also finalizing the requirement to use the median monthly cost-sharing OOPC difference of $16 between 2 enhanced plans in the same service area.

C. Cost-Sharing Out-of-Pocket (OOPC) Software

For CY 2012, CMS will make the Cost-Sharing Out-of-Pocket Cost model (Cost-Sharing OOPC model) available in SAS via the CMS website which will allow plans to calculate Cost-Sharing OOPC estimates for each of their benefit offerings to prepare for meaningful difference negotiations with CMS (see below). Standalone Prescription Drug Plans (PDP), and Medicare Advantage Plans with Prescription Drug coverage (MA-PD) will be encouraged to run their plan benefit structures through the SAS Cost-Sharing OOPC model to ensure meaningful differences between their plan offerings as required by CMS regulations (see 42 CFR §§ 423.272(b)(3)(i) and 423.265(b)(2)). The SAS Cost-Sharing OOPC model will be available no later than Friday, April 8, 2011. Instructions for downloading the model and a User Guide will also be published via the CMS website.

CMS expects PDPs and MA-PDs to prepare CY 2012 plan bids that meet the meaningful difference requirements with their initial submissions, since there will be access to the necessary tools to consistently calculate Cost-Sharing OOPC estimates for each plan prior to bid submission. CMS might not permit revised submissions if a plan's initial bid does not comply with meaningful difference requirements. Ultimately, plan bids that do not meet these requirements will not be approved by CMS. Thus, plans should complete this analysis prior to submitting their bids for the 2012 contract year.

Co-pay Thresholds for Cost Shares

According to 1860D-11(e) of the Social Security Act, the Secretary can only approve a plan if the design of the plan and its benefits are not likely to substantially discourage enrollment by certain Part D eligible individuals. Pursuant to 42 CFR 423.104(d)(2)(iii), tiered cost sharing for non-defined standard benefit designs may not exceed levels annually determined by CMS to be discriminatory.

To implement these requirements, CMS will examine PDP and MA-PD bid (benefit package) data for 2012 to determine acceptable cost sharing thresholds. While EGWPs are not part of the benefit package analysis, sponsors should take into consideration these thresholds when designing their tiered benefits to ensure they are not discriminating and discouraging certain beneficiaries from enrolling in the EGWP.

Consistent with prior years' review, we plan to conduct an analysis to identify drug tier cost-sharing outliers relative to other sponsors' competing benefit packages submitted using the 30-day retail in-network pharmacy copay cost-sharing associated with the 95th percentile across all initially submitted bids consisting of three or more tiers. CMS believes that cost-sharing at the 95th percentile would reflect the level at which a beneficiary could easily identify outliers they would consider to be discriminatory based on other plan offerings. As part of this analysis, we will also take into consideration plan type (basic versus enhanced), the number of drug tiers within a PBP, cost structure (copayment versus coinsurance), tier content and differences between MA-PDs (including cost plans) as well as differences between MA-PDs and PDPs. The table below shows the results of the threshold analysis for the initial 2011 bid submissions.

Copay Cost-Sharing Distribution for 2011 Bid Submissions with Three or More Tiers

		2011 Copay Distribution (Percentiles)			
Tier ID	**Plan Count**	**20th**	**50th**	**70th**	**95th**
1	2846	$2	$5	$6	$10
2	2696	$15	$35	$40	$45
3	2570	$40	$70	$80	$95

Assuming similar benefit designs are submitted for 2012 as they were for 2011, sponsors can expect that CMS will establish 2012 thresholds that are reasonably consistent with the prior year's experience. Therefore, in constructing 2012 PBPs, Part D sponsors should consider the following thresholds that were used as part of the 2011 discrimination review for drug plans with three or more tiers:

Tier 1 over $10
Tier 2 over $45
Tier 3 over $95

Based on the most common tier designs submitted by plans, tier 1 represents preferred generic cost-sharing, tier 2 represents preferred brand cost-sharing and tier 3 represents non-preferred brand cost-sharing. As in 2011, the established threshold for preferred generic, preferred brand and non-preferred brand cost-sharing still apply when the tier level for these categories are shifted based on variations in tier design. For instance, if a sponsor had a 4 tier formulary with

tier 3 as the preferred brand tier (instead of tier 2), the $45 dollar threshold would apply to tier 3. It is important to note that in identifying drug tier outliers, CMS will consider specific benefit design aspects that could justify an exception for the purpose of our discrimination review. For instance, we may allow cost-sharing thresholds for plan benefit designs in which a particular tier represents the specialty tier such that if a plan has a 3 tier formulary which includes a specialty tier, the specialty tier will be held to the specialty tier thresholds, not the thresholds established by the 95th percentile. Atypical tiering structures, such as a two-tier formulary, will also be considered. Because of the additional standardization in tier design required for 2012, the benefits offered will have a distribution that is unique to each tier structure. Therefore, CMS will be able to refine the target cost-sharing thresholds and expects to establish cost-sharing threshold levels for all 2012 PBP tiers based on the standardized models described in the next section.

During 2011, CMS will increase scrutiny of the expected cost-sharing amounts incurred by beneficiaries under coinsurance tiers, in order to more consistently compare copay and coinsurance cost-sharing impacts. We expect to derive average expected cost sharing amounts for a sponsor's 2012 coinsurance tiers using 2010 PDE drug cost data mapped to 2012 formulary tiers. If a sponsor submits coinsurance values (instead of copayment values) for its non-specialty formulary tiers that are greater than the standard benefit of 25% for non-specialty tiers, CMS may also request documentation from the sponsor on the average expected price for medications on the coinsurance tier(s) in order to better translate the coinsurance value into an average cost-sharing amount for the purpose of our discrimination review.

Consistent with the meaningful difference review, CMS will notify plan sponsors whose benefit structures include drug tiers that exceed our discriminatory cost-sharing threshold limits and conduct negotiation calls as applicable prior to bid approval. Sponsors not meeting our targets will be asked to amend or withdraw their PBPs.

Tier Labeling and Hierarchy

Over the last few years CMS has heard from various beneficiary and advocacy stakeholders and Part D sponsors that a large number of drug tiers, non-standardized labeling of those tiers and formularies using duplicative tier names or tier names that include multiple drug types in the label (e.g., Brand and Generic Drugs) are confusing to beneficiaries especially when trying to compare plans. In order to improve the clarity and consistency of tier designs, CMS revised the PBP and formulary upload software in 2011 to accept a maximum of six drug tiers and established a uniform set of tier label description options based upon the most common tier names used by Part D sponsors. However, CMS believes that additional standardization of the tier structure and number could further improve the comparability of plan offerings by beneficiaries and will simplify the discriminatory cost-sharing analysis performed by CMS.

First, in order to keep drug benefits meaningful to beneficiaries while allowing sponsors adequate flexibility in the Part D benefit design, the 2012 PBP and formulary upload will continue to accept 6 formulary tiers. CMS continues to observe that the vast majority of Part D plan benefit packages reflect benefit designs using five tiers or less, and those plans with six tier designs are similar to those submitted by five tier plans, but typically include an extra non-preferred cost-sharing tier that does not provide a clear additional value to the beneficiary. Therefore, CMS will only allow a 6th tier if it is an excluded-drug-only tier or a tier that provides a meaningful benefit offering such as a $0 vaccine-only tier, a low or $0 cost-sharing tier for special needs plans (SNP) targeting one or more specific conditions (e.g., $0 tier for drugs related to diabetes and/or smoking cessation), or an injectable drug tier with cost-sharing that is at or below the cost-sharing for specialty tier drugs in the other five tiers. Plans offering supplemental benefits for excluded drug coverage are not required to have an optional excluded-drug-only tier and may continue to offer excluded drugs on tiers that are shared by Part D covered drugs.

Second, CMS is establishing tier labels and hierarchy to reflect standards established by industry and assist in our analysis of discriminatory benefit practices. CMS updated its regulations at §423.104(d)(2) by adding paragraph (iii) to specify that tiered cost-sharing for non-defined standard benefit designs may not exceed levels (or cost-sharing thresholds) annually determined by CMS to be discriminatory. In order to accurately evaluate whether tiered cost-sharing is discriminatory, there needs to be a consistency between the tier names adopted by the plan sponsors and the cost-sharing thresholds CMS established as part of its discriminatory analyses. Some of the variation in tier labeling that currently exists in Part D presents challenges for the discriminatory cost-sharing analyses, and does not lend itself to a common understanding of how competing plans compare in terms of tier offerings. As a result, beginning with the 2012 bid submissions, CMS expects sponsors to utilize certain tier labels and tiering hierarchy consistent with the industry standards already established in the market place. These standard tier names and hierarchy reflect the common tier patterns utilized by the majority of sponsors in 2011 and will provide for a more comprehensible description of the overall tier offering as it relates to the drug content and assigned cost-sharing. In addition, the 2012 tier labeling convention parallels the anticipated tier name options in the formulary submission module, in that only a single description can be selected as the tier name. The new tier label standards do not preclude sponsors from continuing to include brands and generics on the same tier as long as the drugs placed on the tier are associated with the same cost-sharing level.

Below is a chart depicting the tier labels and hierarchy as observed currently in the industry. Although the 2012 PBP tool will allow plans' to select tier names and hierarchies that are not consistent with the options described below, CMS expects plans to only submit PBPs that reflect the 2012 models. CMS will have difficulty determining whether a plan's tier cost-sharing structure is discriminatory if Part D sponsors submit plan benefit packages that do not reflect these industry standards. CMS will require Part D sponsors to provide justification that the

PBP's cost-sharing tier structure is not discriminatory for any PBP that differs from the expected models. In addition because of the ACA provision that moved the annual enrollment period from November to October, CMS will have a shortened time frame for review and approval of 2012 Part D bids and may not have enough time to approve bids that are incomplete or otherwise challenging to evaluate. CMS strongly encourages Part D sponsors to ensure that their initial submissions due on June 7, 2011 are complete and consistent with CMS policy and guidance, to avoid the risk of being denied participation in the program. In addition, sponsors must ensure that the formularies submitted in advance of the bids only include a 6th tier that provides a meaningful offering. We further note that the tier names submitted on the formularies should match those names submitted in the PBP, with the exception of free text field names in the formulary submission module that are not available in the PBP. These free text field names on the formulary submission should be limited to describing the $0 vaccine-only tier, the targeted chronic disease SNP tier with low or $0 cost-sharing, or other 6th tier meaningful benefit that cannot be adequately described by the existing 2012 PBP tier label options. As in previous years, excluded-drug-only tiers will not be reflected on formulary submissions.

Because the 2012 PBP tier label options are unchanged from 2011, plan sponsors will be permitted to customize the tier label for the 6th tier via the summary of benefits (SB) hard copy change process for 2012, as long as it reflects the meaningful benefit being offered on that tier. SB hard copy changes for 2012 should not be submitted by the sponsor for injectable drugs and excluded-drug-only tiers since they already have specific tier labels included in the PBP. CMS will also permit sponsors to enter a Part D PBP note describing 6th tier offerings for which they will be requesting an SB hard copy tier name change. CMS will revise the PBP for 2013 to allow customization of the 6th tier label.

2012 Tier Labels and Hierarchy

		2012 Tier Label					
2012 Tier Structure	**2012 Option**	**Tier 1**	**Tier 2**	**Tier 3**	**Tier 4**	**Tier 5**	**Optional Tier 6***
2 Tier	A	Generic or Preferred Generic	Brand or Preferred Brand	---	---	---	---
3 Tier	A	Generic or Preferred Generic	Brand or Preferred Brand	Specialty Tier	---	---	---
	B	Generic or Preferred Generic	Preferred Brand	Non-Preferred Brand	---	---	---
4 Tier	A	Generic or Preferred Generic	Preferred Brand	Non-Preferred Brand	Specialty Tier	---	---
	B	Preferred Generic	Non-Preferred Generic	Preferred Brand	Non-Preferred Brand	---	---
5 Tier	A	Preferred Generic	Non-Preferred Generic	Preferred Brand	Non-Preferred Brand	Specialty Tier	optional
	B	Preferred Generic	Non-Preferred Generic	Preferred Brand	Non-Preferred Brand	Injectable Drugs	optional
	C	Preferred Generic	Non-Preferred Generic	Preferred Brand	Injectable Drugs	Specialty Tier	optional
	D	Generic or Preferred Generic	Preferred Brand	Non-Preferred Brand	Injectable Drugs	Specialty Tier	optional

*The optional 6th tier can be used as an excluded-drug-only tier or for other meaningful offerings such as a $0 vaccine-only tier.

Gap Coverage

Consistent with our bid submission requirements provided at 42 CFR 423.265, a Part D sponsor's bid submission must reflect differences in benefit packages or plan costs that CMS determines to represent substantial differences relative to a sponsors other bid submissions. This being the case, CMS expects that the additional gap coverage of generic (non-applicable) drugs offered by plans to reflect meaningful enhancements over the standard prescription drug benefit, which provides 14% generic drug cost coverage in the gap for CY 2012.

To determine how much additional coverage in the coverage gap over the basic benefit would be recognized as substantially different, CMS considered the amount of additional coverage provided by the Part D sponsors in their plan benefit packages for CY 2011. CMS found that the majority of plans offering coverage in the gap had cost-sharing levels for generics equal to 50%

coinsurance or less, and brand cost-sharing at 60% coinsurance or less. Since the majority of plans reflect additional coverage of at least 50% in the gap for generics and 40% coverage of brands in the gap, CMS intends to scrutinize any 2012 plans that provide gap coverage at or below 30% of the cost of generic or brand drugs - in other words, the plan's benefit has beneficiary cost-sharing during the coverage gap that is equal to or more than 70% coinsurance. For example, if a plan submits a basic benefit package which reflects the defined-standard benefit structure of 86% coinsurance for generics during the coverage gap and submits another enhanced plan that reflects more than 70% coinsurance for generics during the coverage gap, CMS will evaluate whether the enhanced plan is substantially different from what is offered under the sponsor's basic plan in accordance with our meaningfully different policies.

Plan Corrections

The plan correction module will be available in HPMS for 2012 PBPs for a limited period, from mid-September until October 1, 2011. Organizations may request a plan correction only after their contract has been approved. This limited timeframe will ensure that correct bid information will be available for review on the Medicare Prescription Drug Plan Finder in time for the open enrollment start date. Only changes to the PBP that are supported by the BPT are allowed during the plan correction period.

CMS expects that sponsors' requests for plan corrections will be very rare. A request for a plan correction indicates the presence of inaccuracies and/or the incompleteness of a bid and calls into question an organization's ability to submit correct bids and the validity of the final actuarial certification and bid attestation. Please be advised that an organization requesting a plan correction will receive a compliance notice.

CMS did not receive any comments on the plan corrections guidance provided in the draft call letter; however we did receive public comments requesting a shorter and streamlined review period and that we release the SB Hard Copy Change Request Module on June 6 in order to allow plans to submit SB requests sooner. We appreciate the comments provided; however, CMS will not shorten the review period for the SB standardized document, which is currently a 10-day review. We believe that the current review process is sufficient and will work with plans to ensure timely approval. For CY2012, CMS will not change the date that the HPMS Summary of Benefits Hard Copy Change Request Module will be available; however, we will consider this for the next calendar year, if possible.

Specialty Tier Threshold

For contract year 2012, we will maintain the $600 threshold for drugs on the specialty tier. Thus, only Part D drugs with negotiated prices that exceed $600 per month may be placed in the specialty tier, and the specialty tiers will be evaluated and approved in accordance with section

30.2.4 of Chapter 6 of the Medicare Prescription Drug Benefit Manual. In addition to cost calculations, CMS considers claims history in reviewing the placement of drugs on Part D sponsors' specialty tiers. Except for newly approved drugs for which Part D sponsors would have little or no claims data, CMS will approve specialty tiers that only include drugs on specialty tiers when their claims data demonstrates that the majority of fills exceed the specialty tier cost criteria. Part D sponsors should be prepared to provide CMS the applicable claims data during the formulary review process.

Appendix A-1 – Contract Year 2012 Guidance for Medicare Advantage, Medicare Advantage Prescription Drug, and Section 1876 Cost Contract Plan Renewals

I. MA PBP Renewal and Non-Renewal Guidance

Each renewal/non-renewal option available to MAOs for CY 2012 is outlined in Appendix A-2 and summarized below. Some of these actions can be effectuated by MAOs in the HPMS Plan Crosswalk, while others require explicit prior approval from CMS. Note that CMS will not permit plan renewals across product types. For example, we will not permit MA-only plans to renew as, or consolidate into, MA-PD plans (and vice versa), Health Maintenance Organization (HMO) plans to renew as, or consolidate into, Preferred Provider Organization (PPO) plans (and vice versa); HMO plans or PPO plans to renew as, or consolidate into, Private-Fee-for-Service (PFFS) plans (and vice versa); Special Needs Plans (SNPs) to renew as, or consolidate into, non-SNP MA plans (and vice versa); and section 1876 cost contract plans to renew as, or consolidate into, MA plans (and vice versa). With limited exceptions (outlined below) CMS will not permit consolidation of PBPs, regardless of plan type, across contracts. Furthermore, CMS will not permit a non-segmented plan to convert to a segmented plan and to request that current enrollees be transitioned to plan segments.

1. ***New Plan Added***

An MAO may create a new PBP for the following contract year with no link to a PBP it offers in the current contract year in the HPMS Plan Crosswalk. In this situation, beneficiaries electing to enroll in the new PBP must complete enrollment requests, and the MAO offering the MA plan must submit enrollment transactions to MARx.

2. ***Renewal Plan***

An MAO may continue to offer a current PBP that retains all of the same service area for the following year. The renewing plan must retain the same PBP ID number as in the previous contract year in the HPMS Plan Crosswalk. Current enrollees are not required to make an enrollment election to remain enrolled in the renewal PBP, and the MAO will not submit enrollment transactions to MARx for current enrollees. New enrollees must complete enrollment requests, and the MAO will submit enrollment transactions to MARx for those new enrollees. Current enrollees of a renewed PBP must receive a standard Annual Notice of Change (ANOC) notifying them of any changes to the renewing plan.

3. ***Consolidated Renewal Plan***

MAOs are permitted to combine two or more entire PBPs offered in the current contract year into a single renewal plan in the HPMS Plan Crosswalk so that all enrollees in the combined plans are under one PBP with the same benefits in the following contract year. However, an

MAO may not split a current PBP among more than one PBP for the following contract year. An MAO consolidating one or more entire PBPs with another PBP must designate which of the renewal PBP IDs will be retained following the consolidation. The renewal PBP ID will be used to transition current enrollees of the plans being consolidated into the designated renewal plan. This is particularly important with respect to minimizing beneficiary confusion when a plan consolidation affects a large number of enrollees.

Current enrollees of a plan or plans being consolidated into a single renewal plan will not be required to take any enrollment action, and the organization will not submit enrollment transactions to MARx for those current members. However, the MAO may need to submit updated 4Rx data to CMS for the current enrollees affected by the consolidation. New enrollees must complete enrollment requests, and the MAO will submit enrollment transactions to MARx for those new enrollees. Current enrollees of a consolidated renewal plan must receive a standard ANOC.

4. ***Renewal Plan with a Service Area Expansion (SAE)***

An MAO may continue to offer the same local MA PBP but add one or more new service areas (i.e., counties) to the plan's service area in the following contract year. This is known as a service area expansion, or SAE. Organizations that include any new service area additions to a PBP should have submitted an SAE application to CMS for review and approval. An MAO renewing a plan with a SAE in the HPMS Plan Crosswalk must retain the renewed PBP's ID number in order for all current enrollees to remain enrolled in the same plan in the following contract year.

Current enrollees of a PBP that is renewed with a SAE will not be required to take any enrollment action, and the MAO will not submit enrollment transactions to MARx for those current enrollees. New enrollees must complete enrollment requests, and the MAO will submit enrollment transactions to MARx for those new enrollees. Current enrollees of a renewed PBP with a SAE must receive a standard ANOC notifying them of any changes to the renewing plan.

5a. ***Renewal Plan with a Service Area Reduction (SAR) and No Other MA Options Available***

An MAO offering a local MA plan may reduce the service area of a current contract year's PBP. This is known as a service area reduction, or SAR. An MAO renewing a plan with a SAR must retain the renewed PBP's ID number in the HPMS Plan Crosswalk so that current enrollees in the renewal portion of the service area remain enrolled in the same plan in the following contract year. Current enrollees in the renewal portion of the service area will not be required to take any enrollment action, and the MAO will not submit enrollment transactions in MARx for these current members. Current enrollees in the renewal portion of the service area must receive a standard ANOC notifying them of any changes to the renewing plan.

For the CY 2012 contract year, current plan enrollees in reduced service areas will be disenrolled at the end of 2011. These individuals affected by the SAR will need to elect another plan. The MAO will submit disenrollment transactions pursuant to instructions that CMS will release later this year.

The MAO will send a termination notice to enrollees in the reduced portion of the service area that includes notification of special election period (SEP) and Medigap guaranteed issue rights. Only when there are no other MA options in the reduced service area, the MAO may offer current enrollees in the reduced portion of the service area the option of remaining enrolled in the renewal plan consistent with CMS continuation area policy as provided under 42 CFR 422.74(b)(3)(ii). If an MAO elects to offer current enrollees in the reduced service area the option of remaining enrolled in the renewal plan, the MAO may provide additional information, in addition to the termination notice, about the option to remain enrolled in the plan for CY 2012. However no specific CY 2012 plan information can be shared with any beneficiaries prior to October 1, 2011. Any current enrollees in the reduced portion of the service area who wish to continue their enrollment must complete an enrollment request, and the organization must submit enrollment transactions to MARx for those members.

5b. ***Renewal Plan with a Service Area Reduction (SAR) When the MAO Will Offer Another PBP in the Reduced Portion of the Service Area***

An MAO offering a local MA plan may elect to reduce the service area of a current contract year's PBP and make the reduced area part of a new or renewal MA PBP service area in the following contract year. An MAO renewing a plan with a SAR must retain the renewed PBP's ID number in the HPMS Plan Crosswalk so that current enrollees in the renewal portion of the service area remain enrolled in the same plan in the following contract year. Current enrollees in the renewal portion of the service area will not be required to take any enrollment action, and the MAO will not submit enrollment transactions to MARx for these current members. These individuals must receive a standard ANOC notifying them of any changes to the renewing plan.

Current enrollees in the reduced portion of the service area must be disenrolled, and the MAO must submit disenrollment transactions to MARx for these individuals, pursuant to instructions that CMS will release later this year. The MAO will send a termination notice to current enrollees in the reduced portion of the service area that includes notification of special election period (SEP) and Medigap guaranteed issue rights. If the MAO offers one or more MA plans in the reduced portion of the service area, it may offer current enrollees in the reduced portion of the service area the option of enrolling in that plan (or those plans). However, no specific CY 2012 plan information can be shared with any beneficiaries prior to October 1, 2011. Any current enrollees in the reduced portion of the service area who wish to enroll in another MA plan offered by the same organization in the reduced service area must complete an enrollment request, and the organization must submit enrollment transactions to MARx for those members.

6. ***Terminated Plan (Non-Renewal)***

An MAO may elect to terminate a current PBP for the following contract year and must notify CMS in writing (by sending an email to MA_Applications@cms.hhs.gov) by the first Monday in June,[6] pursuant to 42 CFR 422.506(a)(2)(i). However, even absent written notification to CMS, an MAO's failure to submit a timely bid to CMS constitutes a voluntary non-renewal by the sponsor. In this situation, the MAO will not submit disenrollment transactions to MARx for affected enrollees. CMS will disenroll these individuals from the MA plan at the end of the current contract year. These individuals must make a new election for their Medicare coverage for the following contract year. Regardless of whether these individuals elect to enroll in another plan offered by the same or another MAO, or to revert to Original Medicare and enroll in a PDP, they must complete an enrollment request, and the enrolling organization or sponsor must submit enrollment transactions to MARx. If these individuals do not make a new MA plan election prior to the beginning of the following contracting year, they will have Original Medicare coverage as of January 1st of the following contract year.

Enrollees in terminated PBPs will be sent a termination notice by the terminating plan that includes notification of a special election period and Medigap guaranteed issue rights, as well as information about alternative options. For more information about non-renewal processes and beneficiary notification requirements, refer to our forthcoming HPMS memorandum providing non-renewal and service area reduction guidance and model notices, to be released this summer.

7a, 7b, 8a, 8b, 9a, and 9c. ***Non-Network and Partial Network PFFS Plans Transitioning to Partial or Full Network PFFS Plans***

As provided under 42 CFR 422.114(a)(3), PFFS plans in certain counties ("network counties" with two network plans available) must operate with networks. We have historically required organizations to establish separate contracts for PFFS non-network, partial network, and network plans. CMS has not typically allowed plans to move members from one contract to another, and contract-to-contract moves are currently not possible in the HPMS Plan Crosswalk. However, CMS created an exception to this rule for CYs 2010 and 2011, which we will continue for CY 2012, in anticipation of a large number of transitions from non- or partial network PFFS plans to partial or full network PFFS plans due to the PFFS network requirements. The permissible PFFS transitions are outlined below. We note that some of these scenarios involve consolidations of whole PFFS PBPs and others involve transitions of some, but not all, counties of current non-network and partial network PFFS PBPs.

MAOs must complete the outlined PFFS renewal options by submitting a crosswalk exception request through HPMS. CMS will provide detailed technical instructions for completing a crosswalk exception request through HPMS in forthcoming guidance. Requests will be reviewed

[6] CY 2012 bids are due no later than June 6, 2011.

and, if approved, the action will be on behalf of the requesting MAO. In addition, for those transitions that will involve some, but not all, counties of current non-network and partial network PFFS PBPs, MAOs must submit enrollment transactions to MARx for individuals residing in consolidating counties (i.e., where the contract and PBP number will be different in 2012) following the instructions that CMS will release later this year.

7a. ***Non-Network PFFS Plan Transitioning to a Partial Network PFFS Plan***

An MAO with a PFFS non-network contract may consolidate one or more current non-network PFFS PBPs into a new or renewal partial network PFFS PBP under a separate contract held by the same legal entity. HPMS will record the consolidation of one or more PBPs following the submission and approval of an exceptions request (per the instructions outlined above).

Current enrollees of a PFFS non-network plan or plans being consolidated into a new or renewal PFFS partial network plan will not be required to take any enrollment action, and the organization will not submit enrollment transactions to MARx for those current members, although it may need to submit updated 4Rx data to CMS for the current enrollees affected by the consolidation. New enrollees must complete enrollment requests, and the MAO will submit enrollment transactions to MARx for those new enrollees. Current enrollees of the consolidated PFFS partial network plan must receive a standard ANOC.

7b. ***Some Counties of a Non-Network PFFS Plan Transitioning to a Partial Network PFFS Plan***

An MAO with a PFFS non-network contract may consolidate some counties in the service area of a current non-network PFFS PBP into a single new or renewal partial network PFFS PBP under a separate contract held by the same legal entity. Current enrollees in the remaining counties in the non-network PFFS PBP may remain in that non-network PBP in the following contract year provided the MAO follows the rules for a renewal plan with a SAR described elsewhere in this guidance.

Following the submission of an exceptions request (per the instructions outlined above) and its approval, the MAO must submit enrollment transactions to MARx for current enrollees in the counties affected by the SAR who will be transitioned to a new or renewing partial network PBP under a separate contract held by the same legal entity. CMS will provide specific instructions for the submission of these transactions later in the year. New enrollees must complete enrollment requests, and the MAO will submit enrollment transactions to MARx for those new enrollees as usual. Current enrollees transitioned to the PFFS partial network plan must receive a standard ANOC.

8a. ***Non-Network PFFS Plan Transitioning to a Full Network PFFS Plan***

An MAO with a PFFS non-network contract may consolidate one or more current entire non-network PFFS PBPs into a new or renewal full network PFFS PBP under a separate contract held by the same legal entity. HPMS will record the consolidation of one or more PBPs following the submission and approval of an exceptions request (per the instructions outlined above).

Current enrollees of a PFFS non-network plan or plans being consolidated into a new or renewal PFFS full network plan will not be required to take any enrollment action, and the organization will not submit enrollment transactions to MARx for those current members, although it may need to submit updated 4Rx data to CMS for the current enrollees affected by the consolidation. New enrollees must complete enrollment requests, and the MAO will submit enrollment transactions to MARx for those new enrollees. Current enrollees of the consolidated PFFS full network plan must receive a standard ANOC.

8b. ***Some Counties of a Non-Network PFFS Plan Transitioning to a Full Network PFFS Plan***

An MAO with a PFFS non-network contract may consolidate some counties in the service area of a current non-network PFFS PBP into a single new or renewal full network PFFS PBP under a separate contract held by the same legal entity. Current enrollees in the remaining counties in the non-network PFFS PBP may remain in that non-network PBP in the following contract year provided the MAO follows the rules for a renewal plan with a SAR described elsewhere in this guidance.

Following the submission of an exceptions request (per the instructions outlined above) and its approval, the MAO must submit enrollment transactions to MARx for current enrollees in the counties affected by the SAR who will be transitioned to a new or renewing full network PBP under a separate contract held by the same legal entity. CMS will provide specific instructions for the submission of these transactions later in the year. New enrollees must complete enrollment requests, and the MAO will submit enrollment transactions to MARx for those new enrollees. Current enrollees transitioned to the PFFS full network plan must receive a standard ANOC.

9a. ***Partial Network PFFS Plan Transitioning to a Full Network PFFS Plan***

An MAO with a PFFS partial network contract may consolidate one or more current partial network PFFS PBPs into a new or renewal full network PFFS PBP under a separate contract held by the same legal entity. HPMS will record the consolidation of one or more PBPs following the submission and approval of an exceptions request (per the instructions outlined above).

Current enrollees of a PFFS partial network plan or plans being consolidated into a new or renewal PFFS full network plan will not be required to take any enrollment action, and the organization will not submit enrollment transactions to MARx for those current members. New

enrollees must complete enrollment requests, and the MAO will submit enrollment transactions to MARx for those new enrollees. Current enrollees of the consolidated PFFS full network plan must receive a standard ANOC.

9b. ***Some Counties of a Partial Network PFFS Plan Transitioning to a Full Network PFFS Plan***

An MAO with a PFFS partial network contract may consolidate some counties in the service area of a current partial network PFFS PBP into a single new or renewal full network PFFS PBP under a separate contract held by the same legal entity. Current enrollees in the remaining counties in the partial network PFFS PBP may remain in that partial network PBP in the following contract year provided the MAO follows the rules for a renewal plan with a SAR described elsewhere in this guidance.

Following the submission of an exceptions request (per the instructions outlined above) and its approval, the MAO must submit enrollment transactions to MARx for current enrollees in the counties affected by the SAR who will be transitioned to a new or renewing full network PBP under a separate contract held by the same legal entity. CMS will provide specific instructions for the submission of these transactions later in the year. New enrollees must complete enrollment requests, and the MAO will submit enrollment transactions to MARx for those new enrollees. Current enrollees transitioned to the PFFS full network plan must receive a standard ANOC.

10. ***Consolidation of a Renewal Dual Eligible SNP (D-SNP) with a D-SNP with a State Contract***

An MAO currently offering one or more D-SNP PBPs with no State contracts may consolidate those PBPs into a single renewal PBP that is a D-SNP with a State contract (offered by the same MAO under the same contract and containing the applicable service area of all consolidating PBPs). The organization must retain one of the current year plan IDs as the renewal plan ID for the following contract year.

Current eligible enrollees are not required to make an enrollment election to remain enrolled in the consolidated renewal PBP, and the MAO will not submit enrollment transactions to MARx for those current eligible enrollees. However, the MAO must submit disenrollment transactions for current enrollees who are no longer eligible for the renewing D-SNP's designation, pursuant to instructions CMS will release later this year.

Current eligible enrollees of the consolidated PBP (including newly transitioned enrollees) must receive an ANOC. Current enrollees whose enrollment is terminated because they are no longer eligible for the new State contracted D-SNP's designation must be sent a disenrollment notice that includes information about other plan options, as well as additional details about Medigap

rights and/or SEP rights, as applicable. A CMS model for this special disenrollment notice will be provided in forthcoming guidance.

11. MAO with a Renewing D-SNP that Also Creates a New Medicaid Subset D-SNP and Transitions Eligible Enrollees into the New Medicaid Subset D-SNP

An MAO that renews a current D-SNP that retains the same service area for CY 2012 and also creates a new Medicaid subset D-SNP PBP for the following contract year may transition the subset of current enrollees who are eligible for the new Medicaid subset into the new Medicaid subset D-SNP PBP and may retain current enrollees who are not eligible for the new Medicaid subset D-SNP in the renewing D-SNP. The renewing plan must retain the same PBP ID number as in the previous contract year. MAOs that meet the criteria for this renewal option must complete and submit a request through HPMS. CMS will provide detailed technical instructions for completing a crosswalk exception request through HPMS in forthcoming guidance. Requests will be reviewed and, if approved, the MAO will be permitted to submit enrollment transactions to transition eligible current enrollees into the new Medicaid subset D-SNP. Current enrollees not eligible for the new Medicaid subset D-SNP are not required to make an enrollment election to remain enrolled in the renewal PBP, and the MAO will not submit enrollment transactions to MARx for these current enrollees not eligible for the new Medicaid subset D-SNP. The MAO must submit enrollment transactions for current enrollees eligible for the new Medicaid subset D-SNP in order to enroll them in the new Medicaid subset D-SNP pursuant to instructions that CMS will release later this year. New enrollees in either the renewing or new Medicaid subset D-SNP must complete enrollment requests, and the MAO will submit enrollment transactions to MARx for those new enrollees.

Current enrollees not eligible for the new Medicaid subset D-SNP and who remain in the renewal D-SNP PBP must receive a standard ANOC. Current enrollees transitioned to the new Medicaid subset D-SNP must also receive a standard ANOC.

12. Renewing D-SNP in a Multi-State Service Area with a SAR to Accommodate State Contracting Efforts in Portions of that Service Area

As MAOs make efforts to comply with State contracting requirements for CY 2013, we are aware that the nature of negotiations with States may particularly impact MAOs with D-SNPs that operate across State lines. CMS will therefore allow a narrow renewal exception described below.

An MAO that renews a current D-SNP PBP operating in a multi-State service area (a service area that covers counties in more than one state) may reduce the service area of the current contract year's PBP to accommodate State contracting in portions of the service area. The MAO may then transition enrollees in the reduced area, who are thus no longer eligible for the renewed D-SNP PBP, into a new or renewal SNP service area in the following contract year.

The renewing plan must retain the same PBP ID number as in the previous contract year so that current enrollees in the renewal portion of the service area remain enrolled in the same plan in the following contract year. MAOs must complete this renewal option by submitting a crosswalk exception request through HPMS. CMS will provide detailed technical instructions for completing a crosswalk exception request through HPMS in forthcoming guidance. Requests will be reviewed and, if approved, the MAO will be permitted to submit enrollment transactions to transition eligible current enrollees into a new or renewal D-SNP. Current enrollees who remain eligible for the renewing D-SNP PBP are not required to make an enrollment election to remain enrolled in the renewal PBP, and the MAO will not submit enrollment transactions to MARx for these current enrollees. The MAO must submit enrollment transactions for current enrollees being transitioned to a new or renewal D-SNP in order to enroll them in the new or renewal SNP pursuant to instructions that CMS will release later this year. New enrollees in any of the plans affected by this transition must complete enrollment requests, and the MAO will submit enrollment transactions to MARx for those new enrollees.

Current enrollees who remain in the renewal D-SNP PBP must receive a standard ANOC. Current enrollees transitioned to a new or renewal D-SNP must also receive a standard ANOC.

13a. ***D-SNP that Transitions Current Enrollees to a New D-SNP with a Different Designation and Less Restrictive Eligibility Requirements***

An MAO currently offering a D-SNP PBP that has requested conversion to a different D-SNP type under the same MAO contract may transition current eligible enrollees into its newly created D-SNP PBP of the new SNP type. If the new D-SNP type has less restrictive eligibility requirements than the original D-SNP, the MAO may retain current eligible enrollees in the newly designated D-SNP PBP because all current enrollees will remain eligible for the new D-SNP with the new designation.

MAOs must complete this renewal option by submitting a crosswalk exception request through HPMS. CMS will provide detailed technical instructions for completing a crosswalk exception request through HPMS in forthcoming guidance. Requests will then be reviewed and, if approved, CMS will complete the transition on behalf of the organization.

Current enrollees of the newly designated D-SNP with expanded eligibility criteria are not required to make an enrollment election to be transitioned to the newly created D-SNP PBP, and the MAO will not submit enrollment transactions to MARx for these current enrollees. New enrollees must complete enrollment requests, and the MAO will submit enrollment transactions to MARx for those new enrollees. Current eligible enrollees remaining in the D-SNP must receive an ANOC.

13b. ***D-SNP that Transitions Some Current Enrollees to a New D-SNP with a Different Designation and More Restrictive Eligibility Requirements Consistent with the New D-SNP's State Contract***

An MAO currently offering a D-SNP PBP that has requested conversion to a different D-SNP type under the same MAO contract may transition current eligible enrollees into its newly created D-SNP PBP of the new SNP type. If the new D-SNP type has more restrictive eligibility requirements than the original D-SNP (for example, because the MAO is contracting with a State and a condition of this contract is that the plan enroll a Medicaid subset), the MAO may retain current eligible enrollees in the new D-SNP with the new designation.

MAOs must complete this renewal option by submitting a crosswalk exception request through HPMS. CMS will provide detailed technical instructions for completing a crosswalk exception request through HPMS in forthcoming guidance. Requests will then be reviewed and, if approved, CMS will complete the transition on behalf of the organization.

Current enrollees who are eligible for the new D-SNP with the more restrictive designation are not required to make an enrollment election to be transitioned to the newly created D-SNP PBP, and the MAO will not submit enrollment transactions to MARx for these current eligible enrollees. New enrollees must complete enrollment requests, and the MAO will submit enrollment transactions to MARx for those new enrollees. Current eligible enrollees remaining in the D-SNP must receive an ANOC.

Current enrollees whose enrollment is terminated because they are no longer eligible for the new D-SNP's designation must be sent a disenrollment notice that includes information about other plan options, as well as additional details about Medigap rights and/or SEP rights, as applicable. A CMS model for this special disenrollment notice will be provided in forthcoming guidance.

14. ***Renewing SNP with Ineligible or "Disproportionate Share" Members***

As provided under MIPPA and section 3205(c) of the Affordable Care Act, SNPs may only enroll individuals who meet the plan's specific eligibility criteria; they may no longer enroll and serve a "disproportionate share" of individuals who do not meet the targeted criteria or condition. Also pursuant to MIPPA, chronic care SNPs (C-SNPs) may only enroll and serve individuals with certain chronic conditions, as specified by CMS.

Many SNPs currently include members: (1) who enrolled prior to January 1, 2010 under the "disproportionate share" policy (i.e., the members did not meet the special needs criteria at the time of enrollment); or (2) who were enrolled in a C-SNP as of January 1, 2010, but no longer met the special needs criteria as of that date. In both of these circumstances, rather than require the MAO offering these SNPs to involuntarily disenroll these members as of December 31, 2010 because they no longer met the SNP's targeted criteria, CMS required the MAOs to allow these individuals to continue to be enrolled through CY 2011. However, effective CY 2012, SNPs that

include members who enrolled under the two circumstances described above will be required to disenroll those individuals if they do not request enrollment in a different plan prior to January 1, 2012. MAOs will not be permitted to transition these current enrollees into other MA plans offered by the organization. However, MAOs must retain any of these enrollees whose circumstances change and who regain special needs status prior to January 1, 2012.

The process for disenrollment of ineligible members by January 1, 2012, will be as follows:

- No later than June 30, 2011, MAOs offering SNPs must provide their account managers with the total number of non-special needs individuals who continued to be enrolled in these SNPs as of January 1, 2011.
- By no later than July 29, 2011, CMS will issue an HPMS memorandum that will provide further details about the disenrollment process, and will include model notices to be sent to affected enrollees. We anticipate that the model notices will incorporate information about other plan options, as well as additional details about Medigap rights and/or SEP rights, as applicable.
- MAOs must then notify each affected enrollee no later than September 30, 2011, that s/he will be disenrolled effective January 1, 2012, and will need to enroll in another plan prior to that date if he/she wants MA coverage for CY 2012. This notice must include information about other plan options, as well as additional details about Medigap rights and/or SEP rights as applicable.
- By December 31, 2011, the MAO must submit disenrollment transactions to MARx for those individuals who do not meet the plan's specific eligibility criteria, pursuant to instructions that CMS will release this year.

Please refer to the renewal plan guidance provided in this Call Letter for the notification requirements for current SNP enrollees other than those described above. Enrollees who will need to be disenrolled because they lose their special needs status in 2011 must be sent a disenrollment notice that includes information about other plan options, as well as additional details about Medigap rights and/or SEP rights, as applicable.[7] MAOs must retain any of these enrollees whose circumstances change and who regain their special needs status during their period of deemed continued eligibility, as described in section 50.2.5 of the MA Enrollment and Disenrollment Guidance.

MAOs must retain any of these enrollees through their period of deemed continued eligibility, and also retain enrollees whose circumstances change and who regain their special needs status

[7] Plans should note that the notification policy in this paragraph applies to those SNP enrollees who lost special needs status in 2011 *not* to disproportionate share enrollees who were not eligible for the SNP as of January 1, 2010.

during such period, as described in section 50.2.5 of the MA Enrollment and Disenrollment Guidance.

Section 1876 Cost Contract Renewal and Non-Renewal Guidance

In general, the MA renewal and non-renewal guidance above applies to section 1876 cost contracts that submit PBPs.

A section 1876 cost contract may not, like MA plans, offer separate PBPs. Instead, a cost contract may offer supplemental benefits as separate collections of benefits under its contract for purposes of Medicare Plan Finder and Medicare & You. Because such benefit collections are not considered separate PBPs, a cost contract, unlike an MA plan, is not considered to have terminated a PBP. In the HPMS plan crosswalk, cost contracts are required to consolidate any collection of benefits that have been marked as "terminated" with another collection of benefits. Thus, instead of disenrolling the individual as in the transactions identified in the MA renewal and non-renewal guidance above, the cost contract must send an ANOC to enrollees specifying the benefit changes and notifying the beneficiary that he or she will remain enrolled in the cost contract's A and B-only package (with or without Part D depending on the individual's original election), or, if the enrollee so chooses, may receive one of the cost contract's other benefit packages.

Appendix A-2 – Contract Year 2012 Guidance for Medicare Advantage and Medicare Advantage Prescription Drug Plan Renewals

	Activity	Guidelines	Renewal Effectuation Method	Systems Enrollment Activities	Enrollment Procedures	Beneficiary Notifications
1	New Plan (PBP) Added	An MAO creates a new plan benefit package (PBP).	**HPMS Plan Crosswalk Definition:** A new plan added for 2012 that is not linked to a 2011 plan. **HPMS Plan Crosswalk Designation:** New Plan	The MAO **must submit enrollment transactions** for 2012.	New enrollees must complete an enrollment request.	None
2	Renewal Plan	An MAO continues to offer a CY 2011 MA PBP in CY 2012 and retains all of the same service area. **The same PBP ID number must be retained** in order for all current enrollees to remain in the same MA PBP in CY 2012.	**HPMS Plan Crosswalk Definition:** A 2012 plan that links to a 2011 plan and retains all of its plan service area from 2011. The 2012 plan must retain the same plan ID as the 2011 plan **HPMS Plan Crosswalk Designation:** Renewal Plan	**The renewal PBP ID must remain the same** so that current enrollees will remain in the same PBP ID. The MAO **does not submit enrollment transactions** for current enrollees.	No enrollment request is required for current enrollees to remain enrolled in the renewal PBP in 2012. New enrollees must complete enrollment requests.	Current enrollees are sent a standard ANOC.

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	Activity	Guidelines	Renewal Effectuation Method	Systems Enrollment Activities	Enrollment Procedures	Beneficiary Notifications
3	Consolidated Renewal Plan	An MAO ***combines one or more whole MA PBPs*** of the same type offered in CY 2011 into a single renewal PBP so that all current enrollees in combined PBP are offered the same benefits in CY 2012. The MAO must designate which of the renewal PBP IDs will be retained in CY 2012 after consolidation. CMS will not allow for consolidations across contracts (with limited exceptions for some renewal options, as described elsewhere in this guidance). Only whole PBPs may be consolidated; a CY 2011 PBP may not be split among different PBPs in CY 2012. **Note:** If an MAO reduces a service area when consolidating PBP, it must follow the rules for a renewal plan with SAR described elsewhere in this guidance.	**HPMS Plan Crosswalk Definition:** One or more 2011 plans that consolidate into one 2012 plan. The 2012 plan ID must be the same as one of the consolidating 2011 plan IDs. **HPMS Plan Crosswalk Designation:** Consolidated Renewal Plan	**The MAO's designated renewal PBP ID must remain the same** so that CMS can consolidate enrollees into the designated renewal PBP ID in CMS systems. The MAO **does not submit enrollment transactions** for current enrollees. The MAO may have to submit 4Rx data for individuals whose PBP number changed.	No enrollment request is required for current enrollees to remain enrolled in the renewal PBP in 2012. New enrollees must complete enrollment request.	Current enrollees are sent a standard ANOC.

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	Activity	Guidelines	Renewal Effectuation Method	Systems Enrollment Activities	Enrollment Procedures	Beneficiary Notifications
4	Renewal Plan with an SAE	**This option is available to local MA plans only.** An MAO continues to offer a CY 2011 local MA PBP in CY 2012 and retains all of the same PBP service area, but also adds one or more new service areas. **The same PBP ID number must be retained** in order for all current enrollees to remain in the same MA PBP in CY 2012.	**HPMS Plan Crosswalk Definition:** A 2012 plan that links to a 2011 plan and retains all of its plan service area from 2011, but also adds one or more new counties. The 2012 plan must retain the same plan ID as the 2011 plan. **HPMS Plan Crosswalk Designation:** Renewal Plan with an SAE **Note**: If the 2012 plan has both an SAE and a SAR, the plan must be renewed as a renewal plan with a SAR.	**The renewal PBP ID must remain the same** so that current enrollees in the remaining in the service area will remain in the same PBP ID. The MAO **does not submit enrollment transactions** for current 2011 enrollees. The MAO submits enrollment transactions for new enrollees.	No enrollment request is required for current enrollees to remain enrolled in the renewal PBP in 2012. New enrollees must complete enrollment request.	Current enrollees are sent a standard ANOC.

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	Activity	Guidelines	Renewal Effectuation Method	Systems Enrollment Activities	Enrollment Procedures	Beneficiary Notifications
5a	Renewal Plan with a SAR and no other MA options available	**This option is available to local MA plans only.** An MAO reduces the service area of a CY 2011 MA PBP and the reduced service area is not contained in another MA PBP offered by the same organization or any other MAO. The MAO **may offer** the option to individuals in the reduced portion of the service area for CY 2012 to enroll in its remaining PBP if no other MA plans are available (see 42 CFR 422.74(b)(3)(ii)). **Note:** One renewal plan with a SAR may have counties that should follow the guidance provided in 5a, and other counties in the SAR that should follow the guidance provided under 5b (i.e., the guidance provided in 5a and 5b may both apply to a single plan).	**HPMS Plan Crosswalk Definition:** A 2012 plan that links to a 2011 plan and only retains a portion of its plan service area. The 2012 plan must retain the same plan ID as the 2011 plan. **HPMS Plan Crosswalk Designation:** Renewal Plan with a SAR **Note**: If the 2012 plan has both an SAE and a SAR, the plan must be renewed as a renewal plan with a SAR	The MAO **must submit disenrollment transactions** for individuals residing in the reduced portion of the service area for whom it does not collect an enrollment request. The MAO **does not submit enrollment transactions** for current enrollees in the renewal portion of the service area.	Enrollees impacted by the SAR need to complete an enrollment request if the MAO offers the option of continued enrollment (see 42 CFR 422.74(b) (3) (ii)).	The MAO sends a termination notice to current enrollees in the reduced service area that includes notification of SEP and guaranteed issue Medigap rights. The MAO may also provide affected enrollees additional information, in addition to the termination notice, about the option to remain enrolled in the plan if the MAO elects to offer enrollment to enrollees in the reduced portion of the service area. Current enrollees in the renewal portion of the service area receive the standard ANOC.

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	Activity	Guidelines	Renewal Effectuation Method	Systems Enrollment Activities	Enrollment Procedures	Beneficiary Notifications
5b	Renewal Plan with a SAR when the MAO will offer another PBP in the reduced portion of the service area	**This option is available to local MA plans only.** An MAO reduces the service area of a CY 2011 MA PBP and the reduced service area is part of a new or renewal PBP offered by that MAO in 2012. The MAO **may market** to enrollees in the reduced service area any other PBP offered in the reduced service area for CY 2012. Affected enrollees who elect to enroll in another MA plan offered in the reduced service area must submit an enrollment request. **Note:** One renewal plan with a SAR may have counties that should follow the guidance provided in 5a and other counties in the SAR that should follow the guidance provided under 5b (i.e., the guidance provided in 5a and 5b may both apply to a single plan**).**	**HPMS Plan Crosswalk Definition:** A 2012 plan that links to a 2011 plan and only retains a portion of its plan service area. The 2012 plan must retain the same plan ID as the 2011 plan. **HPMS Plan Crosswalk Designation:** Renewal Plan with a SAR **Note**: If the 2012 plan has both an SAE and a SAR, the plan must be renewed as a renewal plan with a SAR.	The MAO **must submit transactions to disenroll individuals** residing in the reduced portion of the service area. The MAO **submits enrollment transactions** to enroll beneficiaries who have requested enrollment in other PBP offered in the reduced service area.	Enrollees impacted by the SAR **need to complete enrollment requests** if they elect to enroll in another PBP (plan) in the same organization or a different MA plan.	The MAO sends a termination notice to current enrollees in the reduced portion of the service area that includes notification of SEP and guaranteed issue Medigap rights. The MAO may also provide additional information, in addition to the termination notice, including instructions on how to complete an enrollment request to switch to another PBP offered by the same organization. Current enrollees in the renewal portion of the service area receive the standard ANOC.

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	Activity	Guidelines	Renewal Effectuation Method	Systems Enrollment Activities	Enrollment Procedures	Beneficiary Notifications
6	Terminated Plan (Non-Renewal)	An MAO terminates the offering of a CY 2011 PBP.	**HPMS Plan Crosswalk Definition:** A 2011 plan that is no longer offered in 2012. **HPMS Plan Crosswalk Designation:** Terminated Plan.	The MAO **does not submit disenrollment transactions**. If the terminated enrollee elects to enroll in another MA plan with the same or any other MAO, that organization **must submit enrollment transactions** to enroll the beneficiary.	Terminated enrollees must complete an enrollment request if they choose to enroll in another PBP, even in the same organization.	Terminated enrollees are sent a termination notice that includes notification of SEP and guaranteed issue Medigap rights.
7a	Non-network PFFS plan transitioning to a partial network PFFS plan.	**For PFFS only:** An MAO **consolidates** one or more CY 2011 non-network PFFS PBPs into a single new or renewing CY 2012 partial PFFS PBP under a separate contract held by the same legal entity. Only consolidation of whole PBPs is allowed under this option; PBPs may not be split.	**Exceptions Renewal Request:** Organizations must submit an exceptions request via HPMS and CMS staff will complete the transition on behalf of the organization. **HPMS Plan Crosswalk Designation:** The non-network plan being transitioned must be marked as a terminated plan in the HPMS Plan Crosswalk. The 2012 partial network plan must be active and contain the applicable service area from the terminated plan being renewed.	HPMS will record the consolidation of one or more whole PBPs. The MAO **does not** submit enrollment transactions for current enrollees. MAOs may need to submit updated 4RX data for enrollees affected by the consolidation.	No enrollment request is required for current enrollees to remain enrolled in the renewal PBP in 2012. New enrollees must complete enrollment request.	Current enrollees are sent a standard ANOC.

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	Activity	Guidelines	Renewal Effectuation Method	Systems Enrollment Activities	Enrollment Procedures	Beneficiary Notifications
7b.	Some counties of a non-network PFFS plan transitioning to a partial network PFFS plan.	**For PFFS only:** For the counties in the 2011 non-network PFFS PBP that will remain non-network, the MAO must follow the rules for a renewal plan with SAR described elsewhere in this guidance. For current enrollees residing in the counties in the 2011 non-network PFFS PBP that will be consolidated into a single new or renewing partial network PBP under a separate contract held by the same legal entity, the MAO must submit enrollment transactions.	**Exceptions Crosswalk Request:** Organizations cannot complete the transition of current enrollees to the partial network PFFS plan via the HPMS Plan Crosswalk. Organizations must submit an exceptions request via HPMS . If approved, the MAO will be permitted to submit enrollment transactions. **HPMS Plan Crosswalk Definition:** A 2012 non-network plan that links to a 2011 non-network plan and only retains the available non-network counties in its plan service area. The 2012 plan must retain the same plan ID as the 2011 plan. **HPMS Plan Crosswalk Designation:** Renewal Plan with a SAR.	The MAO **must submit enrollment transactions** to transition current enrollees to the new or renewing partial network PBP under a separate contract held by the same legal entity. For current enrollees that remain in the renewed non-network PFFS plan, the MAO does not submit enrollment transactions.	No enrollment request is required for current enrollees. New enrollees must complete enrollment requests.	Current enrollees are sent a standard ANOC.
8a.	Non-network PFFS plan transitioning to a full network PFFS plan.	**For PFFS only:** An MAO consolidates one or more whole CY 2011 non-network PFFS PBPs into a single new or renewing CY 2012 full network PFFS PBP under a separate contract held by the same legal entity. Under this option, only consolidation of whole PBPs is allowed; PBPs may not be split.	**Exceptions Crosswalk Request:** Organizations must submit an exceptions request via HPMS and CMS staff will complete the transition on behalf of the organization. **HPMS Plan Crosswalk Designation:** The non-network plan being transitioned must be marked as a terminated plan in the HPMS Plan Crosswalk. The 2012 full network plan must be active and contain the applicable service area from the terminated plan being transitioned.	HPMS will record the consolidation of one or more whole PBPs. The MAO **does not submit enrollment transactions** for current enrollees. MAOs may need to submit updated 4RX data for enrollees affected by the consolidation.	No enrollment request is required for current enrollees to remain enrolled in the renewal PBP in 2012. New enrollees must complete enrollment requests.	Current enrollees are sent a standard ANOC.

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	Activity	Guidelines	Renewal Effectuation Method	Systems Enrollment Activities	Enrollment Procedures	Beneficiary Notifications
8b.	Some counties of a non-network PFFS plan transitioning to a full network PFFS plan.	**For PFFS only:** For the counties in the 2011 non-network PFFS PBP that will remain non-network, the MAO must follow the rules for a renewal plan with SAR described elsewhere in this guidance. For current enrollees residing in the counties in the 2011 non-network PFFS PBP that will be consolidated into a single new or renewing full network PBP under a separate contract held by the same legal entity, the MAO must submit enrollment transactions.	**Exceptions Crosswalk Request:** Organizations cannot complete the transition of current enrollees to the full network PFFS plan via the HPMS Plan Crosswalk. Organizations must submit an exceptions request via HPMS. If approved, the MAO will be permitted to submit enrollment transactions. **HPMS Plan Crosswalk Definition:** A 2012 non-network plan that links to a 2011 non-network plan and only retains the available non-network counties in its plan service area. The 2012 plan must retain the same plan ID as the 2011 plan. **HPMS Plan Crosswalk Designation:** Renewal Plan with a SAR	The MAO **must submit enrollment transactions** to transition current enrollees to the new or renewing full network PBP under a separate contract held by the same legal entity. For current enrollees that remain in the renewed non-network PFFS plan the MAO **does not submit enrollment transactions.**	No enrollment request is required for current enrollees. New enrollees must complete enrollment requests.	Current enrollees are sent a standard ANOC.
9a	Partial network PFFS plan transitioning to a full network PFFS plan.	**For PFFS only:** An MAO consolidates one or more CY 2011 partial network PFFS PBPs into a single new or renewing CY 2012 full network PFFS PBP under a separate contract held by the same legal entity. Only consolidation of whole PBPs is allowed; PBPs may not be split.	**Exceptions Crosswalk Request:** Organizations must submit an exceptions request via HPMS and CMS staff will complete the transition on behalf of the organization. **HPMS Plan Crosswalk Designation:** The partial network plan being transitioned must be marked as a terminated plan in the HPMS Plan Crosswalk. The 2012 full network plan must be active and contain the applicable service area from the terminated plan being transitioned.	HPMS will record the consolidation of one or more whole PBPs. The MAO **does not submit enrollment transactions** for current enrollees. MAOs may need to submit updated 4RX data for enrollees affected by the consolidation, as applicable.	No enrollment request is required for current enrollees to remain enrolled in the renewal PBP in 2012. New enrollees must complete enrollment requests.	Current enrollees are sent a standard ANOC.

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	Activity	Guidelines	Renewal Effectuation Method	Systems Enrollment Activities	Enrollment Procedures	Beneficiary Notifications
9b.	Some counties of a partial PFFS plan transitioning to a full network PFFS plan.	**For PFFS only:** For the counties in the 2011 partial network PFFS PBP that will remain partial, the MAO must follow the rules for a renewal plan with SAR described elsewhere in this guidance. For current enrollees residing in the counties in the 2011 partial network PFFS PBP that will be consolidated into a single new or renewing full network PBP under a separate contract held by the same legal entity, the MAO must submit enrollment transactions.	**Exceptions Crosswalk Request:** Organizations cannot complete the transition of current enrollees to the full network PFFS plan via the HPMS Plan Crosswalk. Organizations must submit an exceptions request via HPMS. If approved, the MAO will be permitted to submit enrollment transactions. **HPMS Plan Crosswalk Definition:** A 2012 partial network plan that links to a 2011 partial network plan and only retains the available partial network counties in its plan service area. The 2012 plan must retain the same plan ID as the 2011 plan. **HPMS Plan Crosswalk Designation:** Renewal Plan with a SAR.	The MAO **must submit enrollment transactions** to transition current enrollees to the new or renewing full network PBP under a separate contract held by the same legal entity. For current enrollees that remain in the renewed partial-network PFFS plan the MAO **does not submit enrollment transactions.**	No enrollment request is required for current enrollees. New enrollees must complete enrollment requests.	Current enrollees are sent a standard ANOC.

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	Activity	Guidelines	Renewal Effectuation Method	Systems Enrollment Activities	Enrollment Procedures	Beneficiary Notifications
10.	D-SNP with no State contract consolidating with a D-SNP with a State contract, so that, effectively, an entire D-SNP is transferred into another D-SNP with a state contract and the D-SNP without a State contract no longer exists	**For D-SNPs only**: An MAO offering a CY 2011 D-SNP PBP with no State contract may consolidate with a CY 2012 D-SNP, offered under the same contract, which has a contract with the State.	**HPMS Plan Crosswalk Definition:** Two or more whole 2011 D-SNP plans (PBPs) that consolidate into one 2012 plan. The 2012 plan ID must be D-SNP with the state contract. **HPMS Plan Crosswalk Designation:** Consolidated Renewal Plan	The MAO **does not send enrollment transactions** for current enrollees who will remain enrolled in the 2012 PBP. The MAO **must submit disenrollment transactions** for current enrollees who are ineligible for the renewal PBP.	No enrollment request is required for current eligible enrollees to remain enrolled in the renewal PBP in 2012. New enrollees must complete enrollment requests.	Current enrollees eligible to remain enrolled in the renewal plan receive a standard ANOC. The MAO sends a CMS model disenrollment notice to ineligible current enrollees who are to be disenrolled, which will convey information about other plan options, as well as additional details about Medigap rights and/or SEP rights, as applicable.

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	Activity	Guidelines	Renewal Effectuation Method	Systems Enrollment Activities	Enrollment Procedures	Beneficiary Notifications
11.	Renewing D-SNPs that also creates new Medicaid subset D-SNP and transitions eligible enrollees into the new Medicaid subset D-SNP	**For D-SNPs only**: An MAO renewing a D-SNP plan for 2012 and also creating a new Medicaid subset D-SNP for 2012. A subset of current enrollees under the renewing D-SNP is eligible to be enrolled in the new Medicaid subset D-SNP. The organization must submit enrollment transactions to move the eligible D-SNP enrollees into the new Medicaid subset D-SNP.	**Exceptions Crosswalk Request:** Organizations cannot complete the transition of current eligible enrollees to the new Medicaid subset D-SNP via the HPMS Plan Crosswalk. Organizations must submit an exceptions request via HPMS. If approved, the MAO will be permitted to submit enrollment transactions. **HPMS Plan Crosswalk Definition:** A 2012 D-SNP that links to a 2011 D-SNP and retains all of its plan service area from 2011. The 2012 plan must retain the same plan ID as the 2011 plan. In addition, a new Medicaid subset plan is added for 2012 that is not linked to a 2011 plan. **HPMS Plan Crosswalk Designation:** Renewal Plan (renewing D-SNP designation) AND New Plan (new Medicaid subset D-SNP designation)	**The renewal PBP ID must remain the same** so that the HPMS Plan Crosswalk will indicate that beneficiaries remain in the same PBP ID. The MAO **must submit enrollment transactions** to transition eligible current enrollees into the new Medicaid subset D-SNP. Individual enrollees not transitioned by the submission of enrollment transactions will remain enrolled in the renewing PBP.	No enrollment request is required for current enrollees to remain enrolled in the renewal PBP in 2012. New enrollees must complete enrollment request.	Current enrollees transitioned to the renewal plan receive a standard ANOC. Current enrollees who are transitioned to the new Medicaid subset PBP receive a standard ANOC.

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	Activity	Guidelines	Renewal Effectuation Method	Systems Enrollment Activities	Enrollment Procedures	Beneficiary Notifications
12.	Renewing D-SNP in a multi-state service area with a SAR to accommodate State contracting efforts in portions of that service area	**For D-SNPs only:** An MAO reduces the service area of a CY 2011 D-SNP PBP to accommodate State contracting efforts in a multi-State service area. Current enrollees in the reduced portion of the service area are transitioned to one or more new or renewing CY 2012 D-SNP PBPs. The organization must submit enrollment transactions to move current enrollees in the reduced portion of the CY 2011 D-SNP PBP into the new or renewing CY 2012 D-SNP PBPs.	**Exceptions Crosswalk Request:** Organizations cannot complete the transition of current enrollees to one or more new or renewing CY 2012 D-SNP PBPs via the HPMS Plan Crosswalk. Organizations must submit an exceptions request via HPMS. If approved, the MAO will be permitted to submit enrollment transactions. **HPMS Plan Crosswalk Definition:** A 2012 plan that links to a 2011 plan and only retains a portion of its plan service area. The 2012 plan must retain the same plan ID as the 2011 plan. In addition, a new plan(s) is added for 2012 that is not linked to a 2011 plan(s), or a 2011 plan is renewed in 2012. **HPMS Plan Crosswalk Designation:** Renewal Plan with a SAR AND/OR New Plan AND/OR Renewal Plan	**The renewal PBP ID must remain the same** so that the HPMS Plan Crosswalk will indicate that beneficiaries remain in the same PBP ID The MAO **must submit enrollment transactions** to transition current enrollees in the reduced portion of the service area into a new or renewing D-SNP. Individual enrollees not transitioned by the submission of enrollment transactions will remain enrolled in the renewing PBP.	No enrollment request is required for current enrollees in the remaining portion of the service area to remain enrolled in the renewal PBP in CY 2012. New enrollees must complete enrollment request.	Current enrollees in the renewal portion of the service area receive the standard ANOC. Current enrollees in the reduced portion of the service area who are transitioned to a new or renewal D-SNP PBP receive the standard ANOC.

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	Activity	Guidelines	Renewal Effectuation Method	Systems Enrollment Activities	Enrollment Procedures	Beneficiary Notifications
13a.	D-SNP that transitions current enrollees to a new D-SNP with a different designation and less restrictive eligibility requirements.	**For D-SNPs only**: An MAO offering a CY 2011 D-SNP PBP that requests conversion to a different D-SNP type for CY 2012. The new D-SNP has less restrictive eligibility and all current enrollees remain eligible for the new D-SNP with the new designation.	**Exceptions Crosswalk Request:** Organizations **must** submit an exceptions request via HPMS and CMS staff will complete the transition on behalf of the organization. **HPMS Plan Crosswalk Definition:** The 2011 D-SNP must be marked as a terminated plan in the HPMS Plan Crosswalk. The new 2012D-SNP must be active and contain the applicable service area from the terminated plan being transitioned.	The MAO **does not submit enrollment transactions** for current enrollees.	No enrollment request is required for current enrollees to remain enrolled in the renewal PBP in 2012. New enrollees must complete enrollment requests.	Current enrollees are sent a standard ANOC.
13b.	D-SNP that transitions some current enrollees to a new D-SNP with a different designation and more restrictive eligibility requirements consistent with the new D-SNP's State contract.	**For D-SNPs only**: An MAO offering a CY 2011 D-SNP PBP that requests conversion to a different D-SNP type for CY 2012. The new D-SNP has more restrictive eligibility criteria. A subset of current enrollees is eligible to remain enrolled in the new 2012 D-SNP.	**Exceptions Crosswalk Request:** Organizations **must** submit an exceptions request via HPMS and CMS staff will complete the transition on behalf of the organization. **HPMS Plan Crosswalk Definition:** The 2011 D-SNP must be marked as a terminated plan in the HPMS Plan Crosswalk. The new 2012 D-SNP must be active and contain the applicable service area from the terminated plan being transitioned.	The MAO **does not submit enrollment transactions** for current enrollees who will be transitioned to the new D-SNP. The MAO **submits disenrollment transactions** for current enrollees who are ineligible for the new D-SNP..	No enrollment request is required for current enrollees to remain enrolled in the new PBP in 2012. New enrollees must complete enrollment requests.	Current enrollees who remain eligible for the renewing plan receive a standard ANOC. The MAO sends a CMS model disenrollment notice to ineligible current enrollees who are to be disenrolled, which will convey information about other plan options, as well as additional details about Medigap rights and/or SEP rights, as applicable.

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	Activity	Guidelines	Renewal Effectuation Method	Systems Enrollment Activities	Enrollment Procedures	Beneficiary Notifications
14.	Renewing SNP with ineligible, or "disproportionate share," enrollees.	An MAO renewing a SNP that includes a subset of current enrollees who do not meet the eligibility criteria for enrollment in the SNP ("disproportionate share" enrollees or enrollees affected by change in scope of C-SNP).	**HPMS Plan Crosswalk Definition:** A 2012 plan that links to a 2011 plan and retains all of its plan service area from 2011. The 2012 plan must retain the same plan ID as the 2011 plan **HPMS Plan Crosswalk Designation:** Renewal Plan	The MAO **does not submit enrollment transactions** for current enrollees who meet the SNP eligibility criteria for enrollment and will remain enrolled in the 2012 PBP. Plans must submit disenrollment transactions for current enrollees who were enrolled as of January 1, 2010 and continue to not meet the eligibility criteria for enrollment in the SNP.	No enrollment request is required for enrollees eligible to remain enrolled in the renewal PBP in 2012. New enrollees must complete enrollment requests.	Enrollees who remain eligible for the renewing plan receive a standard ANOC. The MAO sends a CMS model disenrollment notice to ineligible current enrollees who are to be disenrolled, which will convey information about other plan options, as well as additional details about Medigap rights and/or SEP rights, as applicable

Appendix B-1 – CY 2012 PDP PBP Renewal and Non-Renewal Guidance

PDP regions are defined by CMS and consist of one or more entire states (refer to Appendix 3, Chapter 5, of the Prescription Drug Benefit Manual for a map of the 34 PDP regions). Each PDP sponsor's PBPs must be offered in at least one entire region and a PDP sponsor's PBP cannot be offered in only part of a region. Please note that PDP bidding rules require PDP sponsors to submit separate bids for each region to be covered. HPMS only accepts a PDP sponsor's PBPs to cover one region at a time for individual market plans (e.g., a PDP sponsor offering a "national" PDP must submit 34 separate PBP bids in order to cover all PDP regions).

A PDP sponsor may expand the service area of its offerings by submitting additional bids in the PDP regions the sponsor expects to enter in the following contract year, provided the sponsor submits a PDP Service Area Expansion (SAE) application and CMS approves that application and then approves the sponsor's submitted bids for the new region or regions. For more information about the application process, refer to: http://www.cms.hhs.gov/PrescriptionDrugCovContra/04_RxContracting_ApplicationGuidance.asp#TopOfPage.

Conversely, a PDP sponsor may reduce its service area by electing not to submit bids for those regions from which it expects to withdraw. A PDP sponsor must notify CMS in writing (by sending an email to drugbenefitimpl@cms.hhs.gov) of its intent to non-renew one or more plans under a contract by the first Monday in June[8] pursuant to 42 CFR §423.507(a)(2)(i). The same procedure applies to PDPs converting contracts from offering both individual and employer products to employer-only products. However, even absent written notification to CMS, a PDP sponsor's failure to submit a timely bid to CMS constitutes a voluntary non-renewal by the sponsor. (Note that PDP sponsors reducing their service areas must provide notice of their action to affected beneficiaries consistent with regulatory requirements, CMS' PDP Eligibility, Enrollment, and Disenrollment Guidance, Chapter 3 of the Prescription Drug Benefit Manual and CMS non-renewal and service area reduction guidance.)

Each renewal/non-renewal option available to PDP sponsors for CY 2012 is outlined in Appendix B-2 and summarized below. All but one of these actions can be effectuated by PDP sponsors in the HPMS Plan Crosswalk.

1. New Plan Added

A PDP sponsor may create a new PBP for the following contract year with no link to a PBP it offers in the current contract year in the HPMS Plan Crosswalk. In this situation, beneficiaries electing to enroll in the new PBP must complete enrollment requests, and the PDP sponsor offering the PBP must submit enrollment transactions to MARx. No beneficiary notice is required in this case beyond receipt of the Evidence of Coverage (EOC), and other documents as required by current CMS guidance, following enrollment.

[8] CY 2012 bids are due no later than June 6, 2011

2. Renewal Plan

A PDP sponsor may continue to offer a current PBP that retains all of the same service area for the following year. The renewing plan must retain the same PBP ID number as in the previous contract year in the HPMS Plan Crosswalk. Current enrollees are not required to make an enrollment election to remain enrolled in the renewal PBP, and the sponsor will not submit enrollment transactions to MARx for current enrollees. New enrollees must complete enrollment requests, and the sponsor will submit enrollment transactions to MARx for those new enrollees. Current enrollees of a renewed PBP must receive a standard Annual Notice of Change (ANOC) notifying them of any changes to the renewing plan.

3. Consolidated Renewal Plan

PDP sponsors are permitted to combine two or more entire PBPs offered in the current contract year into a single renewal plan in the HPMS Plan Crosswalk. A PDP sponsor may not split a current PBP among more than one PBP for the following contract year. A PDP sponsor consolidating one or more entire PBPs must designate which of the renewal PBP IDs will be retained following the consolidation; the organization's designated renewal plan ID must remain the same in order for CMS to consolidate the beneficiary's election by moving him or her into the designated renewal plan ID. This is particularly important with respect to minimizing beneficiary confusion when a plan consolidation affects a large number of enrollees. When consolidating two existing PBPs into a single renewal PBP, it is permissible for the single renewal PBP to result in a change from:

(1) A basic benefit design (meaning either defined standard, actuarially equivalent standard, or basic alternative benefit designs) to another basic benefit design;

(2) An enhanced alternative benefit design to a basic benefit design; or

(3) An enhanced alternative benefit design to another enhanced alternative benefit design.

We will not, however, permit consolidation of two existing PBPs into a single renewal PBP through the HPMS Plan Crosswalk when it involves a change from a basic benefit design to an enhanced alternative benefit design, since enrollees previously not subject to a supplemental premium under a basic benefit design will have to pay a combined basic and supplemental premium under an enhanced alternative benefit design that may be higher than a basic premium.

Current enrollees of a plan or plans being consolidated into a single renewal plan will not be required to take any enrollment action, and the sponsor will not submit enrollment transactions to MARx for those current members, although it may need to submit updated 4Rx data to CMS for the current enrollees affected by the consolidation. New enrollees must complete enrollment requests, and the sponsor will submit enrollment transactions to MARx for those new enrollees. Current enrollees of a consolidated renewal plan must receive a standard ANOC.

4. Renewal Plan with a Service Area Expansion ("800 Series" EGWPs only)

A PDP sponsor offering an 800 series EGWP PBP in the current contract year may expand its EGWP service area to include additional PDP regions for the following contract year through the Part D application process. In order for currently enrolled beneficiaries to remain in the renewed PBP, the sponsor must retain the same PBP identification number for the following contract year.

Current enrollees will not be required to take any enrollment action, and the sponsor will not submit enrollment transactions to MARx for those current enrollees. New enrollees must complete enrollment requests, and the sponsor will submit enrollment transactions to MARx for those new enrollees. Current enrollees of a renewed PBP with a SAE must receive a standard ANOC notifying them of any changes to the renewing plan.

5. Terminated Plan (Non-Renewal)

A PDP sponsor may elect to terminate a current PBP for the following contract year and must notify CMS in writing (by sending an email to drugbenefitimpl@cms.hhs.gov) by the first Monday in June[9] pursuant to 42 CFR §423.507(a)(2)(i). In this situation, the sponsor will not submit disenrollment transactions to MARx for affected enrollees. When a sponsor terminates a PBP, plan enrollees must make a new election for their Medicare coverage in the following contract year. To the extent that a current enrollee of a terminated PBP elects to enroll in another plan offered by the current or another PDP sponsor – or, alternatively, elects to enroll in an MA plan – he/she must complete an enrollment request, and the enrolling organization or sponsor must submit enrollment transactions to MARx so that those individuals are enrolled. Enrollees of terminated PBPs will be sent a model termination notice that includes notification of a special election period, as well as information about alternative options. For more information about non-renewal processes and beneficiary notification requirements, refer to our forthcoming HPMS memorandum providing non-renewal and service area reduction guidance and model notices, to be released this summer.

6. Consolidated Plans under a Parent Organization

For purposes of ensuring compliance with transition requirements following an acquisition or merger under our significant differences policy, or to make plan transitions following a novation, CMS may elect to combine two or more entire PBPs offered under different contracts (the contracts may be offered by the same legal entity or represent different legal entities). PDP sponsors must complete this renewal option by submitting a crosswalk exception request through HPMS. CMS will provide detailed technical instructions for completing a crosswalk exception request through HPMS in forthcoming guidance. Requests will be reviewed and, if approved, the action will be completed on behalf of the requesting PDP. Current enrollees of a plan or plans being consolidated across contracts in this manner will not be required to take any

[9] CY 2012 bids are due no later than June 6, 2011

enrollment action, and the sponsor will not submit enrollment transactions to MARx for those current members, although it may need to submit updated 4Rx data to CMS for the current enrollees affected by the consolidation. New enrollees must complete enrollment requests, and the sponsor will submit enrollment transactions to MARx for those new enrollees.

Current enrollees of a consolidated renewal plan must receive a special notice along with a standard ANOC. Plan sponsors should use the CMS model for this special notice provided in Appendix C of this Call Letter.

Appendix B-2 – Contract Year 2012 Guidance for Prescription Drug Plan Renewals

	Activity	Guidelines	HPMS Plan Crosswalk	Systems Enrollment Activities	Enrollment Procedures	Beneficiary Notifications
1	New Plan (PBP) Added	PDP sponsor creates a new PBP.	**HPMS Plan Crosswalk Definition:** A new plan added for 2012 that is not linked to a 2011 plan. **HPMS Plan Crosswalk Designation:** New Plan	The PDP sponsor must submit enrollment transactions.	New enrollees must complete an enrollment request.	None.
2	Renewal Plan	A PDP sponsor continues to offer a CY 2011 PBP in CY 2012. **The same PBP ID number must be retained** in order for all current enrollees to remain in the same PBP in CY 2012.	**HPMS Plan Crosswalk Definition:** A 2012 plan that links to a 2011 plan and retains all of its plan service area from 2011. The 2012 plan must retain the same plan ID as the 2011 plan. **HPMS Plan Crosswalk Designation:** Renewal Plan	**The renewal PBP ID must remain the same** so that current enrollees will remain in the same PBP ID. The PBP sponsor **does not** submit enrollment transactions for current enrollees.	No enrollment request for current enrollees to remain enrolled in the renewal PBP in 2012. New enrollees must complete enrollment request.	Current enrollees are sent a standard ANOC.

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	Activity	Guidelines	HPMS Plan Crosswalk	Systems Enrollment Activities	Enrollment Procedures	Beneficiary Notifications
3	Consolidated Renewal Plan	A PDP sponsor combines two or more PBPs offered in CY 2011 into a single renewal PBP for CY 2012. The PDP sponsor must designate which of the renewal PBP IDs will be retained in CY 2012 after consolidation. When a PDP sponsor combines an enhanced PBP with a basic PBP, the HPMS crosswalk only allows a crosswalk to a consolidated PBP that offers a basic benefit design.	**HPMS Plan Crosswalk Definition:** Two or more 2011 plans that consolidate into one 2012 plan. The 2012 plan ID must be the same as one of the consolidating 2011 plan IDs. **HPMS Plan Crosswalk Designation:** Consolidated Renewal Plan	**The PDP sponsor's designated renewal PBP ID must remain the same** so that CMS can consolidate current enrollees into the designated renewal PBP ID. The PDP sponsor **does not** submit enrollment transactions for current enrollees. Sponsors may need to submit updated 4RX data for enrollees affected by the consolidation.	No enrollment request for current enrollees to remain enrolled in the renewal PBP in 2012.	Current enrollees are sent a standard ANOC.
4	Renewal Plan with an SAE (**applicable only to employer/union group waiver plans**)	A PDP sponsor continues to offer an 800 series CY 2011 prescription drug PBP in CY 2012 and expands it s EGWP service area to include additional regions. **The PDP sponsor must retain the same PBP ID number** in order for all current enrollees to remain in the same PBP in CY 2012.	**HPMS Plan Crosswalk Definition:** A 2012 800-series plan that links to a 2011 800-series plan and retains all of its plan service area from 2011, but also adds one or more new regions. The 2012 plan must retain the same plan ID as the 2011 plan. **HPMS Plan Crosswalk Designation:** Renewal Plan with an SAE	**The renewal PBP ID must remain the same** so that current enrollees in the current service area will remain in the same PBP ID. The PDP sponsor does not submit enrollment transactions for current enrollees.	No enrollment request for current enrollees to remain enrolled in the renewal PBP in 2012. New enrollees must complete enrollment request.	Current enrollees are sent a standard ANOC.

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	Activity	Guidelines	HPMS Plan Crosswalk	Systems Enrollment Activities	Enrollment Procedures	Beneficiary Notifications
5	Terminated Plan (Non-Renewal)	A PDP sponsor terminated the offering of a 2011 PBP.	**HPMS Plan Crosswalk Definition:** A 2011 plan that is no longer offered in 2012. **HPMS Plan Crosswalk Designation:** Terminated Plan	The PDP sponsor does not submit disenrollment transactions. If the terminated enrollee elects to enroll in another PBP with the same or another PDP sponsor or MAO, the enrolling PDP sponsor or organization **must submit enrollment transactions** to enroll the terminated enrollees.	Terminated enrollees must complete an enrollment request if they choose to enroll in another PBP, even a PBP offered by the same PDP sponsor.	Terminated enrollees are sent a CMS model termination notice including SEP information and receive a written description of options for obtaining prescription drug coverage in the service area.
6	Consolidated Plans across Contracts under the Same Parent Organization	A parent organization combines two or more whole PBPs under different contracts (the contracts may be the same legal entity or represent different legal entities) as a result of a merger, acquisition, or novation. A PDP sponsor cannot complete this renewal option in the HPMS Plan Crosswalk.	**Exceptions Crosswalk Request:** Organizations must submit an exceptions request via HPMS and CMS staff will complete the transition on behalf of the organization. **HPMS Plan Crosswalk Designation:** The plan being crosswalked must be marked as a terminated plan in the HPMS crosswalk. The remaining 2012 plan must be active and contain the applicable service area from the terminated plan being crosswalked.	PDP sponsors cannot complete this renewal option in the HPMS Plan Crosswalk. CMS will effectuate this renewal option and HPMS will record the consolidation of one or more whole PBPs. The PDP sponsor **does not** submit enrollment transactions for current enrollees. Sponsors may need to submit updated 4RX data for enrollees affected by the consolidation.	No enrollment election for current enrollees to remain enrolled in the renewal PBP in 2012. New enrollees must complete enrollment request.	Current enrollees are sent a special notice (based on the CMS model in Appendix C) along with a standard ANOC.

Appendix C – CMS Model Notice

Contract Year 2012 Guidance for PDP PBP Renewal Option 6 Special Disenrollment Notice

<Insert Date>

IMPORTANT NOTICE: Your Medicare Prescription Drug Coverage Is Changing

Dear <member name>,

<Organization name> will no longer offer <terminating plan name> after December 31, 2011. To make sure you continue to have the same level of Medicare Prescription Drug coverage, **you'll be enrolled in our <receiving plan name> starting < January 1, 2012>.**

Your new plan coverage starts January 1
<Organization name> has approval from Medicare to transfer your enrollment into our <receiving plan name> for 2012. Medicare approved this transfer because the prescription drug benefits in <receiving plan name> are similar to the prescription drug benefits you've been getting in <terminating plan name>. See the attached information about this new plan.

Here's what to do next
If you do nothing, you'll be a member of <receiving plan name> starting <January 1, 2012>. After reviewing your ANOC/EOC, if you have questions about your prescription drug benefits or how this new plan works, including what your costs will be or which pharmacies you can use call <receiving plan name> at <receiving plan phone number>. You should use this letter as proof of coverage under <receiving plan name> until you get your membership card.

You should look carefully at the prescription drug benefits of <receiving plan name> to see if they meet your needs. Although the prescription drug benefits are similar to the prescription drug benefits you have now, they may be different in ways that are important to you.

What if you don't want to be in this plan?
If you don't want to be in <receiving plan name> in 2012, you have the right to choose another Medicare Prescription Drug Plan **anytime between <xxxxx date> and <xxxxx date>.** Your new coverage will start on January 1, 2012.

Here are your options for Medicare Prescription Drug coverage:
Option 1: If you do nothing, you'll get prescription drug coverage from <receiving plan> starting <January 1, 2012>.

Option 2: You can join another Medicare Prescription Drug Plan. Joining a new plan will automatically disenroll you from <receiving plan name>. You should compare the plans available in your area. You can call the plans to get more information about their rules and coverage and find a plan that best meets your needs.

Option 3: You may be able to join a Medicare Advantage plan.
Other information you need to know:
If you qualify for Extra Help (the low-income subsidy) for 2012, you have the right to change plans at any time.

If you have an employer or union group health plan, VA benefits, or TRICARE for Life, call your insurer or benefits administrator to find out how joining a new plan**.**
If you get help from the Medicaid program, contact <State Medicaid Agency and phone number> to learn how joining a new plan affects your Medicaid coverage.

Get help and more information about your options
If you need more information about your changing coverage, please call us at <Phone Number> <Days & Hours>. TTY users should call <insert number >. Tell the customer service representative you got this notice.

To join another Medicare Prescription Drug Plan, you should compare available plans and join one that meets your needs. You should find out which plans cover the prescriptions you take. For help comparing plans and joining a plan that works for you, visit www.medicare.gov, or call 1-800-MEDICARE (1-800-633-4227). TTY users should call 1-877-486-2048. You can also call your State Health Insurance Assistance Program for free personalized counseling at <SHIP phone number>.

To see if your state has a program for people with limited income and resources, call your State Medical Assistance Office at <State Medical Assistance Office Number>. You may be able to get help paying Medicare premiums, deductibles and coinsurance. TTY users should call <State Medical Assistance Office> at <TTY Number>.

Sincerely,
<CEO or other official of PDP organization>

[Insert Federal contracting statement.]

[Insert Material ID number][insert **CMS Approved** *followed by mm/dd/yyyy]*

[“Model Beneficiary Notice for CMS Approved Crosswalk Situations”- (material submission code # 2054).]