February 17, 2006

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

SUBJECT: Advance Notice of Methodological Changes for Calendar Year 2007 for Medicare Advantage (MA) Payment Rates and Part D Payment

In accordance with Section 1853(b)(2) of the Social Security Act (the Act), we are notifying you of proposed changes in the MA capitation rate methodology and risk adjustment methodology applied under Part C of the Act for CY 2007. Preliminary estimates of the national per capita MA growth percentage and other payment methodology changes for CY 2007 are also discussed. For 2007, CMS will announce the MA capitation rates on the first Monday in April, 2006, in accordance with the timetable established in the Medicare Prescription Drug, Improvement, and Modernization Act of 2003 (MMA). This Advance Notice is published 45 days before that date.

For 2007, all rates will be the greater of the 2006 MA capitation rate increased by the minimum percentage increase (the greater of 2 percent or the national per capita MA growth percentage) or the 2007 fee-for-service rate. Attachment I shows the preliminary estimates of the national per capita MA growth percentage component of the minimum percentage increase.

Attachment II sets forth in detail the changes in payment methodology for 2007 for MA organizations. Attachment III provides an overview of Part D payment updates for Medicare Advantage – Prescription Drug (MA-PD) plans and Prescription Drug Plans (PDPs).

Any changes to employer/union-only group waiver plan payment for 2007 will be issued in future guidance.

In 2007, we will continue paying on a fee-for-service basis for covered clinical trial items and services provided to MA plan members.

Attachment comments or questions may be addressed to:

Deondra Moseley
Centers for Medicare & Medicaid Services
7500 Security Boulevard
S3-16-16
Baltimore, Maryland 21244

Comments also may be submitted electronically to the following address: AdvanceNotice2007@cms.hhs.gov. In order to receive consideration prior to the April 3, 2006 Announcement of MA and PDP capitation rates, comments must be received by 5:00 PM EST on March 3, 2006.

/ s /
Abby L. Block
Director
Center for Beneficiary Choices

/ s /
Solomon Mussey, A.S.A.
Acting Director
Parts C & D Actuarial Group
Office of the Actuary

Attachments

Attachment I

Preliminary Estimate of the National Per Capita Growth Percentage for Calendar Year (CY) 2007

The MMA provides that the minimum percentage increase is the higher of two percent or the national per capita MA growth percentage. The MMA also provides that, in years like 2007 when we are rebasing FFS costs, MA payment rates will be based on the greater of 100 percent of FFS costs or an increase which is the greater of two percent or the Medicare growth percentage, with no adjustment to this percentage for over- or under-estimates for years before 2004.

The current estimate of the change in the national per capita MA growth percentage for aged and disabled enrollees combined in CY 2007 is 6.9 percent. This estimate reflects an underlying trend change for CY 2007 in per capita costs of 2.5 percent and adjustments to the estimates for CY 2006, CY 2005, and CY 2004 aged MA growth percentages of 1.1 percent, 1.8 percent, and 1.3 percent respectively. Our new estimates for these years are higher than the estimates actually used in calculating the CY 2006 capitation rate book that was published April 4, 2005, and are required by Section 1853(c)(6)(C) of the Act.

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

Table I-1. National Per Capita Growth Percentage

	Aged	Disabled	ESRD	Aged+Disabled
2007 Trend Change	2.3%	3.6%	-0.1%	2.5%
Revision to CY 2006 Estimate	1.2%	0.8%	2.6%	1.1%
Revision to CY 2005 Estimate	1.7%	2.5%	0.6%	1.8%
Revision to CY 2004 Estimate	1.2%	2.4%	1.6%	1.3%
Total Change	6.5%	9.6%	4.7%	6.9%

Note: The total percentage change is multiplicative, not additive and may not exactly match due to rounding.

These estimates are preliminary and could change before the final rates are announced on April 3, 2006. Further details on the derivation of the national per capita MA growth percentage will also be presented in the April 3 announcement.

Attachment II

Changes in the Payment Methodology for Original Medicare Benefits for CY 2007

Section A. Changes to the Risk Adjustment Methods for MA Organizations

1. Update of the Centers for Medicare & Medicaid Services – Hierarchical Condition Category (CMS-HCC) Risk Adjustment Model

Recalibration of the CMS-HCC Risk Adjustment Model: In 2007, CMS will implement an updated version of the current CMS-HCC risk adjustment model. Fee-for-service (FFS) claims data for the years 2002 and 2003 will be used in the recalibration of the model. (Diagnostic data for 2002 predict 2003 expenditures.) As the data are more current than the 1999 and 2000 data used for the current model, the updated model coefficients will reflect newer treatment and coding patterns in FFS Medicare.

As a result of recalibration, all segments of the risk adjustment system will be updated (the community, long-term institutional, new enrollee, and ESRD segments). For this notice we are providing the disease groupings, draft coefficients, and the disease hierarchies for the community model (see Exhibits 1 and 2). Disease groupings are the same as in past models; however, the coefficients will be different. The final coefficients for each of the segments will be provided in the "Announcement of Calendar Year (CY) 2007 Medicare Advantage Payment Rates."

The recalibration of the long-term institutionalized (LTI) segment of the model is being done with a larger sample than was used for the current model. All persons in LTI status in the prediction year (2003) who otherwise meet the criteria for inclusion in the risk adjustment modeling will be used for calibration. The effect of using a larger sample will be to refine the coefficients and better differentiate the costliness of the beneficiaries.

Update to Frailty Factors for PACE and Certain Demonstrations: Since January 2004, CMS has applied a frailty adjustment to payments to PACE organizations and certain demonstrations. The frailty adjuster was developed as a further refinement to risk adjustment to ensure that capitated payments to organizations that serve frail community-based populations were accurate.

The purpose of frailty adjustment is to better predict the Medicare expenditures for community populations with functional impairments that are not reflected in risk adjustment. The current frailty factors were estimated using the Medicare Current Beneficiary Survey (MCBS) cost and use files. Individuals were grouped according to the difficulty they experienced with Activities of Daily Living (ADLs). Their Medicare payments were predicted by the CMS-HCC model, and the difference between actual expenditures and predicted payments (i.e., "residual expenditures") was calculated. The frailty factors were derived based on the residual expenditures for each ADL group (0 ADLs, 1-2 ADLs, 3-4 ADLs, and 5-6 ADLs).

As explained above, CMS is recalibrating the CMS-HCC risk adjustment model for 2007 payment. Recalibration of the CMS-HCC model may change the predicted expenditures for the frail elderly compared to the current model, which in turn may influence the estimated frailty factors. Since the frailty adjuster is applied in conjunction with risk adjustment, the frailty factors must be consistent with the recalibrated risk adjustment model. Thus, CMS intends to recalculate the frailty factors. The new frailty factors will be published in the "Announcement of CY 2007 Medicare Advantage Payment Rates."

FFS Normalization: The FFS normalization factor, used to correct for population and coding changes between the data years used in model calibration and the payment year, will be computed to reflect a new calibration year. The FFS normalization factor is expected to be smaller than the 5% used in 2004, 2005, and 2006 because there will be fewer years between calibration and implementation.

The FFS normalization factor will no longer be applied to the rescaling factor in the ratebook. Instead, in 2007, the FFS normalization factor will be applied to the risk scores. The result of these two approaches is mathematically the same. We will announce the FFS normalization factor in the "Announcement of CY 2007 Medicare Advantage Payment Rates."

Restandardization: Due to the changes in the recalibrated risk adjustment model, county payment rates will be restandardized to reflect new average county risk scores in the FFS sector. The Office of the Actuary (OACT) intends to restandardize the 2006 rates. OACT will then project forward to get the 2007 minimum percentage increase rates using the latest growth trends for 2007. The final 2007 rate for a county will be the greater of the minimum percentage increase rate and the rebased FFS rate.

2. Implementation Issues

Elimination of Diagnostic Radiology Data from the Physician Specialty Type: In the CY 2006 Advance Notice, CMS announced the elimination of diagnostic radiology (Medicare specialty code 30) from the acceptable risk adjustment physician specialty type. In line with this announcement, diagnostic radiology has been excluded from the recalibrated risk adjustment model. This decision applies only to diagnostic radiology and does not impact other radiology codes (e.g., interventional radiology codes).

Addition of Pain Management Data from the Physician Specialty Type: Starting in 2007, CMS will include pain management (Medicare specialty code 72) as an acceptable risk adjustment physician specialty type under the CMS-HCC payment methodology. We have added pain management to the recalibrated risk adjustment model.

3. Transition Payment Blends

From 2004 through 2007, risk adjusted payment is being phased in for all MA plan payments. In 2007 the CMS-HCC model for MA plans will be applied at 100 percent

risk adjusted payment. For the Social Health Maintenance Organizations (S/HMOs), Minnesota Senior Health Options (MSHO)/ Minnesota Disability Health Options (MnDHO), Wisconsin Partnership Program (WPP) and Massachusetts Senior Care Options (SCO) demonstrations, the CMS-HCC model with a supplemental frailty adjuster will be applied in 2007 at 75 percent risk adjusted payment, with the remaining 25 percent being based on the payment methodology for these demonstrations. For Program of All-Inclusive Care for the Elderly (PACE) organizations, the CMS-HCC model with a supplemental frailty adjuster will be applied in 2007 at 75 percent risk adjusted payment, with the remaining 25 percent being based on the PACE payment methodology.

Section B. Budget Neutrality

Beginning in 2003, CMS has implemented risk adjusted payments in a budget neutral manner. Since that time, the budget neutrality amount has been calculated as the difference between payments to organizations at 100 percent of the demographic rate and payments at 100 percent of the risk adjusted rate.

As previously announced by CMS, in 2007 we will begin phasing out risk adjustment budget neutrality. The phase-out will be completed by 2011, when plans will receive no budget neutrality payment adjustment. The budget neutrality phase-out is summarized in the table below. As required by the Deficit Reduction Act of 2005, this is an acceleration of the phase-out schedule described in the February 18, 2005 CY2006 Advance Notice.

Year	Budget Neutrality Percentage
2007	55%
2008	40%
2009	25%
2010	5%
2011	0%

Section C. Regional Plan Stabilization Fund

Section 221 of the MMA added Section 1858(e) to the Act to create a new MA Regional Plan Stabilization Fund. The purpose of the fund is to provide financial incentives to MA organizations to offer MA regional PPO plans in each MA region, and to retain MA regional PPO plans in regions with relatively low MA market penetration. Specifically, the MMA authorizes CMS to make a one-year "national bonus payment" to an organization(s) that offers an MA regional PPO plan in all MA regions in a given year (if there was no such plan offered in all MA regions in the previous year). If no national bonus payment is made in a given year, CMS may use the fund to increase payments to MA regional PPO plans offered in regions that did not have any MA regional PPO plans offered in the prior year. Finally, to encourage plans to remain in regions with relatively low MA market penetration and few MA regional PPO plans, CMS may make retention payments from the fund to MA regional PPO plans.

The MA Regional Plan Stabilization Fund will initially be funded with $10 billion from the HI and SMI Trust Funds. Half of the 25 percent savings generated each year by regional PPO plans whose bids are below the benchmark is also added to the Fund. As stipulated by the MMA, these funds will be available for payments on January 1, 2007. CMS will provide additional information on the stabilization fund at a later date. Limitations to the stabilization fund can be found in §422.458.

Section D. ESRD Bidding Policy

We had planned to incorporate ESRD costs in MA plan bids beginning in 2007. However, CMS needs additional time to further evaluate different methodological approaches for incorporating ESRD costs. Therefore, for 2007, ESRD enrollee costs will not be included in the plan A/B bid. We will provide further information in the 2007 MA-PD Call Letter on how to reflect an adjustment for costs or savings for ESRD enrollees in the bid. As a result, the 2007 payment methodology for ESRD enrollees in MA plans is unchanged from 2006.

Attachment III

Overview of Payment for Medicare Advantage Prescription Drug Plans (MA-PDs) and Prescription Drug Plans (PDPs)

Section A. Weighting for the National Average Monthly Bid Amount and the Regional Low-Income Premium Subsidy Amount

In calculating the national average monthly bid in §423.279(b)(1) and the regional low-income benchmark premium amount in §423.780(b)(2), PDP plans are no longer receiving an equal weighting and MA-PD plans are no longer receiving a weight based on prior enrollment. Instead, the national average monthly bid, a weighted average of the standardized bid amounts, is calculated based on the number of Part D eligible individuals enrolled in the plan in the reference month in each PDP and MA-PD as a percent of the total number of Part D eligible individuals enrolled in all Part D plans, with the exception of MSA plans, fallbacks, MA private fee-for-service plans, specialized MA plans for special needs individuals, PACE programs under section 1894, and contracts under reasonable cost reimbursement contracts. The regional low-income benchmark premium amount, a weighted average of the Part D basic premiums, is calculated based on the number of Part D eligible-individuals enrolled in each PDP or MA-PD plan in the reference month as a percent of the total number of Part D-eligible individuals enrolled in all PDP and MA-PD plans (but not including PACE, private fee-for-service plans or 1876 cost plans) in a PDP region in the same month.

EXHIBIT 1. Draft Community Coefficients for the CMS-HCC Model with Constraints and Demographic Disease Interactions, Used in the Calculation of Monthly Medicare Advantage Payments[1]

Variable	Disease Group	Community Estimate[2]	Constraint[3]
Age/Sex			
Female 0-34 Years		$1,400	
Female 35-44 Years		1,500	
Female 45-54 Years		2,000	
Female 55-59 Years		2,400	
Female 60-64 Years		2,700	
Female 65-69 Years		1,900	
Female 70-74 Years		2,400	
Females 75-79 Years		3,000	
Female 80-84 Years		3,500	
Female 85-89 Years		4,100	
Female 90-94 Years		5,100	
Female 95 Years or Over		5,100	
Male 0-34 Years		700	
Male 35-44 Years		1,100	
Male 45-54 Years		1,300	
Male 55-59 Years		1,900	
Male 60-64 Years		2,600	
Male 65-69 Years		2,100	
Male 70-74 Years		2,700	
Male 75-79 Years		3,400	
Male 80-84 Years		4,000	
Male 85-89 Years		4,800	
Male 90-94 Years		5,400	
Male 95 Years or Over		6,200	
Medicaid Interactions with Age and Sex			
Medicaid Female, <65 Years		900	
Medicaid Female, Aged		1,100	
Medicaid Male, <65 Years		600	
Medicaid Male, Aged		1,300	
Originally-disabled[4] Interactions with Sex			
Originally-Disabled, Female		1,500	
Originally-Disabled, Male		1,200	
Disease Group			
HCC1	HIV/AIDS	6,100	
HCC2	Septicemia/Shock	5,800	
HCC5	Opportunistic Infections	2,700	
HCC7	Metastatic Cancer and Acute Leukemia	10,700	1

EXHIBIT 1. Draft Community Coefficients for the CMS-HCC Model with Constraints and Demographic Disease Interactions, Used in the Calculation of Monthly Medicare Advantage Payments[1] (continued)

Variable	Disease Group	Community	Constraint[3]
HCC8	Lung, Upper Digestive Tract, and Other Severe Cancers	10,700	1
HCC9	Lymphatic, Head and Neck, Brain, and Other Major Cancers	5,000	
HCC10	Breast, Prostate, Colorectal and Other Cancers and Tumors	1,700	
HCC15	Diabetes with Renal or Peripheral Circulatory Manifestation	3,900	
HCC16	Diabetes with Neurologic or Other Specified Manifestation	2,900	
HCC17	Diabetes with Acute Complications	2,400	
HCC18	Diabetes with Ophthalmologic or Unspecified Manifestation	1,700	
HCC19	Diabetes without Complication	1,200	
HCC21	Protein-Calorie Malnutrition	5,300	
HCC25	End-Stage Liver Disease	6,500	
HCC26	Cirrhosis of Liver	3,400	
HCC27	Chronic Hepatitis	2,000	
HCC31	Intestinal Obstruction/Perforation	2,300	
HCC32	Pancreatic Disease	2,500	
HCC33	Inflammatory Bowel Disease	1,800	
HCC37	Bone/Joint/Muscle Infections/Necrosis	3,600	
HCC38	Rheumatoid Arthritis and Inflammatory Connective Tissue Disease	2,400	
HCC44	Severe Hematological Disorders	7,400	
HCC45	Disorders of Immunity	5,500	
HCC51	Drug/Alcohol Psychosis	1,600	2
HCC52	Drug/Alcohol Dependence	1,600	2
HCC54	Schizophrenia	3,300	
HCC55	Major Depressive, Bipolar, and Paranoid Disorders	2,400	
HCC67	Quadriplegia, Other Extensive Paralysis	6,200	3
HCC68	Paraplegia	6,200	3
HCC69	Spinal Cord Disorders/Injuries	3,300	
HCC70	Muscular Dystrophy	3,000	
HCC71	Polyneuropathy	2,100	
HCC72	Multiple Sclerosis	3,100	
HCC73	Parkinson's and Huntington's Diseases	3,600	
HCC74	Seizure Disorders and Convulsions	1,800	
HCC75	Coma, Brain Compression/Anoxic Damage	2,900	4
HCC77	Respirator Dependence/Tracheostomy Status	12,100	
HCC78	Respiratory Arrest	9,400	

EXHIBIT 1. Draft Community Coefficients for the CMS-HCC Model with Constraints and Demographic Disease Interactions, Used in the Calculation of Monthly Medicare Advantage Payments[1] (continued)

Variable	Disease Group	Community	Constraint[3]
HCC79	Cardio-Respiratory Failure and Shock	4,100	
HCC80	Congestive Heart Failure	2,600	
HCC81	Acute Myocardial Infarction	2,300	
HCC82	Unstable Angina and Other Acute Ischemic Heart Disease	2,200	
HCC83	Angina Pectoris/Old Myocardial Infarction	1,500	
HCC92	Specified Heart Arrhythmias	1,900	
HCC95	Cerebral Hemorrhage	2,400	
HCC96	Ischemic or Unspecified Stroke	2,000	
HCC100	Hemiplegia/Hemiparesis	2,700	
HCC101	Cerebral Palsy and Other Paralytic Syndromes	1,400	
HCC104	Vascular Disease with Complications	4,200	
HCC105	Vascular Disease	2,100	
HCC107	Cystic Fibrosis	2,600	5
HCC108	Chronic Obstructive Pulmonary Disease	2,600	5
HCC111	Aspiration and Specified Bacterial Pneumonias	4,900	
HCC112	Pneumococcal Pneumonia, Emphysema, Lung Abscess	1,500	
HCC119	Proliferative Diabetic Retinopathy and Vitreous Hemorrhage	1,800	
HCC130	Dialysis Status	9,300	
HCC131	Renal Failure	2,500	
HCC132	Nephritis	1,200	
HCC148	Decubitus Ulcer of Skin	7,600	
HCC149	Chronic Ulcer of Skin, Except Decubitus	3,000	
HCC150	Extensive Third-Degree Burns	5,300	
HCC154	Severe Head Injury	2,900	4
HCC155	Major Head Injury	1,200	
HCC157	Vertebral Fractures without Spinal Cord Injury	3,300	
HCC158	Hip Fracture/Dislocation	2,900	
HCC161	Traumatic Amputation	4,800	
HCC164	Major Complications of Medical Care and Trauma	1,900	
HCC174	Major Organ Transplant Status	7,000	
HCC176	Artificial Openings for Feeding or Elimination	4,900	
HCC177	Amputation Status, Lower Limb/Amputation Complications	4,200	

EXHIBIT 1. Draft Community Coefficients for the CMS-HCC Model with Constraints and Demographic Disease Interactions, Used in the Calculation of Monthly Medicare Advantage Payments[1] (continued)

Variable	Disease Group	Community Estimate[2]	Constraint[3]
Disabled[4]/Disease Interactions			
D-HCC5	Disabled*Opportunistic Infections	6,100	
D-HCC44	Disabled*Severe Hematological Disorders	3,600	
D-HCC51	Disabled*Drug/Alcohol Psychosis	5,200	
D-HCC52	Disabled*Drug/Alcohol Dependence	2,300	
D-HCC107	Disabled*Cystic Fibrosis	9,000	
Disease Interactions			
INT1	DM*CHF[5]	1,300	
INT2	DM*CVD	1,000	
INT3	CHF*COPD	1,400	
INT4	COPD*CVD*CAD	1,100	
INT5	RF*CHF[5]	1,600	
INT6	RF*CHF*DM[5]	4,300	

[1] The dollar amounts in this table will be converted to relative risk scores for the April 3 Announcement of Medicare Advantage Rates. That is, these dollar amounts will be divided by the national average predicted expenditures to get relative risk scores we will report April 3.

[2] All estimates are rounded to the nearest hundred dollars.

[3] Equal values in this column indicate coefficients that have been constrained to be equal.

[4] Disabled refers to beneficiaries who are Medicare eligible and under 65 years. Originally-disabled refers to beneficiaries who are over 65, but who were eligible for Medicare due to disability.

[5] Beneficiaries with the three-way interaction RF*CHF*DM are excluded from the two-way interactions DM*CHF and RF*CHF. Thus, the three-way interaction term RF*CHF*CM is not additive to the two-way interaction terms DM*CHF and RF*CHF. Rather, it is hierarchical to, and excludes these interaction terms. A beneficiary with all three conditions is not credited with the two-way interactions. All other interaction terms are additive.

DM is diabetes mellitus (HCCs 15-19).
CHF is congestive heart failure (HCC 80).
COPD is chronic obstructive pulmonary disease (HCC 108).
CVD is cerebrovascular disease (HCCs 95, 96, 100, and 101).
CAD is coronary artery disease (HCCs 81-83).
RF is renal failure (HCC 131).

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

EXHIBIT 2. Draft List Of Disease Groups (HCCs) with Hierarchies

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

How Payments are Made with a Disease Hierarchy

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