

# Washington Bulletin

Health care legislative and regulatory update

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**March 2, 2010**

## **CMS Releases Advance Notice of Methodological Changes for CY 2011 for MA Capitation Rates, Part C and Part D Payment Policies and 2011 Call Letter**

On February 19<sup>th</sup> the Centers for Medicare & Medicaid Services (CMS) issued the Advance Notice of changes to methods used to calculate health care capitation rates for payments to Medicare Advantage (MA) organizations for Calendar Year (CY) 2011. The Advance Notice is mandated to be issued annually 45 days before the final rates are announced, and also to address policy and technical changes to payment methodologies for Medicare Advantage (Part C) and Medicare prescription drug (Part D) plans. For 2011, CMS will announce the MA capitation rates on the first Monday in April 2010 (April 5).

This year, CMS is combining the Advance Notice with the annual Call Letter to health plans, which outlines non-payment policy changes for the upcoming calendar year. A [copy](#) of the 98-page letter is available on the CMS website.

### **Highlights of the Advance Notice**

#### **I. Preliminary Estimate of the National Per Capita Growth Percentage for Calendar Year 2011**

The current estimate of the change in the national per capita MA growth percentage for aged and disabled enrollees combined in CY 2011 is 1.38 percent. This estimate reflects an underlying trend change for CY 2011 in per capita costs of 1.75 percent.

The following tables summarize the estimates for the change in the national per capita MA growth percentage for aged/disabled rates and ESRD rates.

#### **National Per Capita MA Growth Percentage – Aged/disabled**

	Aged	Disabled	Aged + Disabled
2011 Trend Change	1.69%	2.07%	1.75%
Revision to CY 2010 Estimate	0.19%	0.45%	0.20%
Revision to CY 2009 Estimate	0.23%	2.37%	0.56%
Revision to CY 2008 Estimate	-0.42%	0.44%	-0.30%
Revision to CY 2007 Estimate	0.10%	-0.26%	0.04%
Revision to CY 2006 Estimate	-0.39%	-0.42%	-0.41%
Revision to CY 2005 Estimate	0.06%	-1.36%	-0.13%
Revision to CY 2004 Estimate	-0.31%	-0.32%	-0.31%
<b>Total Change</b>	<b>1.13%</b>	<b>2.95%</b>	<b>1.38%</b>

## National Per Capita MA Growth Percentage – ESRD

	ESRD
2011 Trend Change	3.78%
2010 Trend Change	1.24%
2009 Trend Change	3.65%
<b>Total Trend</b>	<b>8.90%</b>

The actual percentage change may differ from the preliminary estimate. For the 2010 plan year, the preliminary estimate was a 0.5 percent increase in the growth percentage but the actual change was 0.81 percent.

These estimates are preliminary and could change before the final rates are announced on April 5, 2010 in the Announcement of Calendar Year (CY) 2011 Medicare Advantage Capitation Rates and Medicare Advantage and Part D Payment Policies.

## II. Changes in the Payment Methodology for Original Medicare Benefits for CY 2011

### Section A. Recalibration and Clinical Update of the CMS-HCC Risk Adjustment Model

The CMS-HCC (hierarchical condition categories) risk adjustment model is used to adjust payments for Part C benefits offered by MA plans and PACE organizations to aged/disabled beneficiaries. The CMS-HCC model includes both diseases and demographic factors. There are separate sets of coefficients for beneficiaries in the community, beneficiaries in long-term care institutions, and new enrollees.

#### *Changes to model*

The 2011 model has 87 HCCs, up from 70. The increase in HCCs is a result of new HCCs added to the model and the splitting of several existing HCCs.

HCCs related to two levels of severity of dementia have been added: dementia with complications and dementia without complications.

Two new HCCs related to metabolic disorders are added: “Other significant endocrine and metabolic disorders” and “Morbid Obesity.”

CMS has added “Fibrosis of the Lung and Other Chronic Lung Disorders” and “Exudative Macular Degeneration.”

A number of diseases that are currently included in HCCs with other related conditions have been broken out into their own HCCs. These conditions include quadriplegia, cerebral palsy, ALS and other motor neuron disease, and atherosclerosis of the extremities with ulceration or gangrene. Additional conditions that have been broken out into separate HCCs are pressure ulcers and kidney disease.

The current trio of kidney-related diseases (dialysis status, renal failure, and nephritis) is broken out further by dividing “Renal Failure” into “Acute Renal Failure” and five severity levels of chronic kidney disease (CKD).

The 2011 model consolidates the number of diabetes HCCs from the five HCCs in the current model to three: diabetes with acute complications, diabetes with chronic complications, and diabetes without complications.

The coefficients for the community model continue to have six disease interactions. The institutional set of coefficients now has twelve disease interactions instead of five. It retains two interactions from the current model – Diabetes-CHF and CHF-COPD – and adds ten new disease interaction terms.

The community set of coefficients retains all five existing disabled-disease interactions and adds two additional disabled-disease interactions: Disabled Chronic Pancreatitis and Disabled Complications of Specified Implanted Device or Graft. The institutional set of coefficients retains one of the four disabled-disease interactions – Disabled Opportunistic infections – and adds five new disabled-disease interactions.

CMS continues to include Medicaid as a demographic factor in the CMS-HCC risk adjustment model, which incorporates attributes of title XIX eligible beneficiaries, including low-income status.

### **Comment**

The notice's Attachment V provides draft relative factors for each HCC in each segment of the aged-disabled model. Table 1 provides the draft factors of the community and institutional segments. Table 2 provides the new enrollee factors. Table 3 provides the updated hierarchies for the revised HCCs, and Table 4 provides a comparative list of current and revised HCCs.

### **Section B. New Enrollee Risk Scores for Chronic SNPs**

New enrollee risk scores are demographic-only risk scores and are used as in payment for beneficiaries who are not full risk (do not have 12 months of Part B in the data collection period). MA organizations that offer chronic condition Special Needs Plans (SNPs) have expressed concern that the new enrollee risk scores do not reflect the full risk of their enrollees, given that these beneficiaries must have certain conditions to be enrolled in these plans. For 2011, CMS will develop a methodology that will allow the agency to adjust new enrollee risk scores for beneficiaries enrolled in chronic condition SNPs to take into account the condition(s) that enrollees in these particular SNPs must have as a condition of enrollment. CMS will release the final methodology in the 2011 Announcement.

### **Section C. Normalization Factors**

Below are the preliminary normalization factors for each model. The final normalization factors will be published in the 2011 Announcement.

***C1. Normalization Factor for the CMS-HCC Model*** - The preliminary 2011 normalization factor for the aged-disabled model is 1.031.

***C2. Normalization Factor for the ESRD Dialysis Model*** - The preliminary 2011 normalization factor for the ESRD dialysis model is 1.008.

***C3. Normalization Factor for Functioning Graft Enrollees' Risk Scores*** - The preliminary 2011 normalization factor for the Functioning Graft segment of the ESRD risk adjustment model is the same as that used for the CMS-HCC model: 1.031.

***C4. Normalization Factor for the Rx Hierarchical Condition Category (RxHCC) Model*** - The preliminary 2011 normalization factor for the RxHCC model is 1.029. This normalization factor reflects a trend calculated on three years of risk score data (2006-2008).

#### **Section D. Aged/Disabled MSP Factor**

CMS has recalculated the MSP adjustment factor for working aged and working disabled beneficiaries. The current aged/disabled MSP factor of 0.174 will be revised; the preliminary 2011 aged/disabled MSP factor is 0.163.

#### **Section E. Frailty Adjustment**

***E1. Frailty Adjustment Factors*** - CMS has recalibrated the frailty factors for CY 2011. The purpose of frailty adjustments is to predict the Medicare expenditures of community populations with functional impairments that are unexplained by the CMS-HCC risk adjustment model. For 2011, only payments made to PACE organizations will be adjusted for frailty.

***E2. Frailty Adjustment Transition for PACE organizations*** - PACE frailty scores for payment year 2011 will be calculated at a blend of 25 percent of the frailty factors in use prior to 2008 and 75 percent of the recalibrated frailty factors for 2011.

**Section F. Adjustment for MA Coding Pattern Differences** - For 2011, CMS is proposing a coding pattern adjustment of 3.41 percent.

**Section G. Budget Neutrality** - From 2003 through 2006, CMS implemented risk adjusted payments that were budget neutral to the demographic payments made prior to, and throughout the transition to, full risk adjusted payments by applying to the risk rates 100 percent of the Budget Neutrality (BN) factor. The 2011 BN is now zero percent.

#### **Section H. ESRD Payment**

The final 2011 State rates will be developed by taking into account the Medicare Improvements for Patients and Providers Act of 2008 (MIPPA) carve-out of indirect medical education (IME) and the \$5.25 ESRD user fee.

The current ESRD MSP adjustment factor of 0.215 will be revised; the preliminary 2011 ESRD MSP factor is 0.189. CMS will continue to apply the ESRD MSP adjustment to individual-level payments.

### **III. Changes in the Payment Methodology for Medicare Part D for CY 2011**

#### **Section A. Recalibration and Clinical Update of the RxHCC Risk Adjustment Model**

The RxHCC risk adjustment model is used to adjust payments for Part D benefits offered by stand alone Prescription Drug Plans (PDPs), Medicare Advantage-Prescription Drug plans (MA-PDs), and PACE organizations. In 2011, CMS will implement an updated version of the RxHCC risk adjustment model. The 2011 model will encompass several key changes:

- (1) the use of Part D program data, specifically, the use of Prescription Drug Event (PDE) data to calculate the Part D expenditures used in the recalibration of the model,
- (2) updates to the data years used to recalibrate the model, and
- (3) a clinical revision of the diagnoses included in each prescription drug hierarchical condition category (RxHCC).

### ***Changes to model***

The final revised RxHCC risk adjustment model is the result of clinical input regarding the composition of each RxHCC and of contribution to total medical costs. There are several key changes in the RxHCC model:

- As a result of the clinical revision of the model and changing cost patterns, the 2011 model has 78 RxHCCs, compared with the 84 RxHCCs for the model used for payment years 2006-2010. The decrease in RxHCCs is a net result of the addition of new RxHCCs, the splitting of several existing RxHCCs, and the removal of a number of RxHCCs.
- Instead of a base model with multipliers for low income and long term institutional status, the 2011 RxHCC model will have 5 sets of coefficients: long-term institutional, aged low-income, aged non-low-income, disabled low-income, and disabled non-low-income. In using PDE data, CMS says it was able to observe that these five groups of beneficiaries have distinct differences in costs, making the use of interaction terms for the disabled population unwieldy. In addition, there are variations in costs across RxHCCs in each set of coefficients that uniform multipliers could not accurately accommodate.

### **Section B. LIS Benchmarks**

The intent of the low-income benchmark is to provide fully-subsidized drug coverage options for beneficiaries with limited means, while providing strong incentives for sponsors to bid competitively. The low-income benchmarks are released in August on the CMS website at <http://www.cms.hhs.gov/MedicareAdvtgSpecRateStats/>.

### **Section C. Reinsurance Payment Demonstration**

The Part D Reinsurance Payment Demonstration was implemented as a five-year payment demonstration under which CMS applied an alternative payment methodology for Part D reinsurance. As stated in the 2010 Advance Notice, 2010 is the last year for the Part D Reinsurance Payment Demonstration. Therefore, Part D sponsors with Reinsurance Demonstration plans will not be allowed to offer such plans in 2011.

### **Section D. Payment Reconciliation**

Pursuant to section 1860D-15(e) of the Social Security Act and the regulations at 42 CFR 423.336, the risk percentages and payment adjustments for Part D risk sharing are unchanged from contract year 2010. The risk percentages for the first and second thresholds remain at 5 percent and 10 percent of the target amount respectively for 2011. The payment adjustments for the first and second corridors are 50 percent and 80 percent respectively.

### **Section E. Medicare Part D Benefit Parameters: Annual Adjustments for Defined Standard Benefit in 2011**

In accordance with section 1860D-2(b) of the Social Security Act, CMS must update the statutory parameters for the defined standard Part D prescription drug benefit each year. The following table reflects these adjustments.

**Updated Part D Benefit Parameters for Defined Standard Benefit, Low-Income Subsidy, and Retiree Drug Subsidy**

**Annual Percentage Increases**

	Annual percentage trend for 2010	Prior year revisions	Annual percentage increase for 2010
Applied to all parameters but (1)	4.63%	-4.13%	0.31%
CPI (all items, U.S. city average): Applied to (1)	1.58%	-1.64%	-0.08%

**Part D Benefit Parameters**

	2010	2011
<b>Standard Benefit</b>		
Deductible	\$310	\$310
Initial Coverage Limit	\$2,830	\$2,840
Out-of-Pocket Threshold	\$4,550	\$4,550
Total Covered Part D Spend at Out-of-Pocket Threshold (2)	\$6,440.00	\$6,447.50
Minimum Cost-Sharing in Catastrophic Coverage Portion of the Benefit		
Generic/Preferred Multi-Source Drug	\$2.50	\$2.50
Other	\$6.30	\$6.30
<b>Full Subsidy-Full Benefit Dual Eligible (FBDE) Individuals</b>		
Deductible	\$0.00	\$0.00
Copayments for Institutionalized Beneficiaries		
Maximum Copayments for Non-Institutionalized Beneficiaries		
Up to or at 100% FPL		
Up to Out-of-Pocket Threshold (1)		
Generic/Preferred Multi-Source Drug (3)	\$1.10	\$1.10
Other (3)	\$3.30	\$3.30
Above Out-of-Pocket Threshold	\$0.00	\$0.00
Over 100% FPL		
Up to Out-of-Pocket Threshold		
Generic/Preferred Multi-Source Drug	\$2.50	\$2.50
Other	\$6.30	\$6.30
Above Out-of-Pocket Threshold	\$0.00	\$0.00
<b>Full Subsidy-Non-FBDE Individuals</b>		
Eligible for QMB/SLMB/QI, SSI or applied and income at or below 135% FPL and resources ≤ \$6,600 (individuals) or ≤ \$9,910 (couples) (4)		
Deductible	\$0.00	\$0.00
Maximum Copayments up to Out-of-Pocket Threshold		
Generic/Preferred Multi-Source Drug	\$2.50	\$2.50
Other	\$6.30	\$6.30
Maximum Copayments above Out-of-Pocket Threshold	\$0.00	\$0.00
<b>Partial Subsidy</b>		
Applied and income below 150% FPL and resources below \$11,010 (individual) or \$22,010 (couple)		
Deductible	\$63.00	\$63.00
Coinsurance up to Out-of-Pocket Threshold	15%	15%
Maximum Copayments above Out-of-Pocket Threshold		
Generic/Preferred Multi-Source Drug	\$2.50	\$2.50
Other	\$6.30	\$6.30
<b>Retiree Drug Subsidy Amounts</b>		
Cost Threshold	\$310	\$310
Cost Limit	\$6,300	\$6,300

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

(2) Amount of total drug spending required to attain out-of-pocket threshold in the defined standard benefit if beneficiary does not have prescription drug coverage through a group health plan, insurance, government-funded health program or similar third party arrangement.

(3) The increases to the LIS deductible, generic/preferred multi-source drugs and other drugs copayments are applied to the unrounded 2010 values of \$62.93, \$1.10, and \$3.31, respectively.

(4) The actual amount of resources allowable will be updated for contract year 2011.

#### IV. Medicare Part D Benefit Parameters for the Defined Standard Benefit: Annual Adjustments for 2011

##### *I. Annual Percentage Increase in Average Expenditures for Part D Drugs Per Eligible Beneficiary*

The following parameters are updated using the “annual percentage increase” (see table above):

**Deductible:** From \$310 in 2010 and rounded to the nearest multiple of \$5.

**Initial Coverage Limit:** From \$2,830 in 2010 and rounded to the nearest multiple of \$10.

**Out-of-Pocket Threshold:** From \$4,550 in 2010 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 2010, 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 2010, and rounded to the nearest multiple of \$0.05.

**Deductible for Low Income (Partial) Subsidy Eligible Enrollees:** From \$632 in 2010 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 2010, and rounded to the nearest multiple of \$0.05.

#### Highlights of Provisions of the Call Letter

Announcements of a combined calendar listing with side-by-side key dates and timelines applicable to MA, MA-PD, Part D and cost-based plans. The calendar contains important operational dates for plans, such as the date that CMS will begin accepting bids, dates for non-renewing plans, and dates for beneficiary mailings.

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