

Issue Brief

FEDERAL ISSUE BRIEF • FEBRUARY 23, 2015

KEY POINTS

- Calendar year 2016 Medicare Advantage and Part D prescription drug programs are expected to increase revenue by 1.05 percent
- Draft call letter proposes steps to ensure that plans maintain accurate provider directories
- Draft letter proposes to work with Part D sponsors that offer limited access to preferred cost sharing pharmacies in their networks

CMS Issues Notice For CY 2016 Medicare Advantage Capitation Rates

The Centers for Medicare and Medicaid Services has released proposed changes for the coming year for the Medicare Advantage and Part D Prescription Drug Programs.

The Advance Rate Notice proposes changes in payments that will affect plans differently depending on a variety of factors. On average, when combined with expected growth in plan risk scores due to coding, CMS says the expected revenue change would be a positive growth of 1.05 percent. Plans that have shown quality improvement and have demonstrated a focus on customer satisfaction would see additional growth. Plan payment levels will continue to be somewhat higher than the equivalent payments in fee-for-service.

The 2016 Draft Call Letter proposes steps to ensure that plans maintain accurate provider directories and make those directories widely available, helping enrollees better understand the providers available to them. In addition, CMS proposes to work with Part D sponsors that offer limited access to preferred cost sharing pharmacies in their networks to ensure all beneficiaries have access to affordable coverage.

The Advance Notice and draft Call Letter are available at: <http://www.cms.hhs.gov/MedicareAdvtgSpecRateStats/> and selecting “Announcements and Documents.” Comments can be submitted by March 6, 2015. The 2016 Final Rate Announcement and Call Letter will be published on Monday, April 6, 2015.

The material is in six attachments. Attachment I show the preliminary estimates of the national per capita MA growth percentage and the national Medicare fee-for-service growth percentage. Attachment II sets forth changes in the Part C payment methodology for CY 2016. Attachment III sets forth the changes in payment methodology for CY 2016 for Part D benefits. Attachment IV presents the annual adjustments for CY 2016 to the Medicare Part D benefit parameters for the defined standard benefit. Attachment V presents the preliminary risk adjustment factors. Attachment VI contains the draft CY 2016 Call Letter for MA organizations; section 1876 cost-based contractors; prescription drug plan sponsors; demonstrations; Programs of All-Inclusive Care for the Elderly organizations; and employer and union-sponsored group plans, including both employer/union-only group health plans and direct contract plans.

4712 Country Club Drive
Jefferson City, MO 65109

P.O. Box 60
Jefferson City, MO 65102

573/893-3700
www.mhanef.com



COMMENT

The material is 172 pages. It is straight forward reciting the provisions and explanations of law. Below are brief excerpts from the document/attachments.

Recent Trends in Medicare Advantage and Part D

- Enrollment continues to grow – MA enrollment has increased by 42 percent since passage of the Affordable Care Act to an all-time high of more than 16 million beneficiaries, with nearly 30 percent of Medicare beneficiaries enrolled in an MA plan.
- Plan quality continues to improve – in 2015, CMS estimates that 60 percent of MA enrollees will be enrolled in a 4 or 5 star plan, compared to an estimated 17 percent back in 2009.
- Premiums remain affordable – average premiums today are lower than before the ACA went into effect, dropping 6 percent between 2010 and 2015.

ATTACHMENT I. PRELIMINARY ESTIMATES OF THE NATIONAL PER CAPITA GROWTH PERCENTAGE AND THE NATIONAL MEDICARE FEE-FOR-SERVICE GROWTH PERCENTAGE FOR CALENDAR YEAR 2016

The ACA establishes a new methodology for calculating each MA county rate as a percentage of Fee-for-Service (FFS) spending in each respective county. The ACA provides for a transitional period during which each county rate is calculated as a blend of the pre-ACA rate set under section 1853(k)(1) of the Social Security Act (the “applicable amount”) and the new FFS-based ACA rate set under section 1853(n)(2) of the Social Security Act (the “specified amount”). For 2016, most counties will be fully transitioned to the new rate

methodology, while others will continue to be based on a blended rate.

Section A. MA Growth Percentage

The current estimate of the change in the national per capita MA growth percentage for aged and disabled enrollees combined in CY 2016 is 2.68 percent. This estimate reflects an underlying trend change for CY 2016 in per capita cost of 1.14 percent.

Section B. FFS Growth Percentage

Section 1853(n)(2) of the Act requires that the specified amount for a county be calculated as a percentage of the county FFS costs. The proposal’s Table I-2 provides the current estimate of the change in the Aged/Disabled FFS United States per capita cost, which will be used for the county FFS portion of the benchmark.

ATTACHMENT II. CHANGES IN THE PART C PAYMENT METHODOLOGY FOR CY 2016

Section A. MA Benchmark, Quality Bonus Payments and Rebate

Section 1853(c)(1)(D)(ii) of the Act requires CMS to rebase the county FFS rates, which form the basis of the specified amount, periodically, but not less than once every three years. When the rates are rebased, CMS updates its estimate of each county’s FFS costs using more current FFS claims information. CMS plans to rebase the county FFS rates for 2016.

A1. Applicable Amount

The applicable amount is the pre-ACA rate established under section 1853(k)(1) of the Act. As CMS will rebase the rates in 2016, for 2016, the applicable amount is the greater of: 1) the county’s 2016 FFS rate or 2) the 2015 applicable

continued

amount increased by the CY 2016 National Per Capita Medicare Advantage Growth Percentage.

A2. Specified Amount

The specified amount is based upon the following formula. (2016 FFS rate minus IME phase-out amount) X (applicable percentage + applicable percentage quality increase)

- IME phase-out amount is the indirect costs of medical education phase-out amount as specified at section 1853(k)(4);
- Applicable percentage is a statutory percentage applied to the county's base payment amount, as described at section 1853(n)(2)(B); and
- Applicable percentage quality increase, referred to in this document as the quality bonus payment percentage.

To determine the CY 2016 applicable percentages for counties in the 50 states and the District of Columbia, CMS will rank counties from highest to lowest based upon their 2015 average per capita FFS costs, because 2015 is the most recent FFS rate-rebasing year prior to 2016. CMS is publishing the 2016 applicable percentages by county with the Advance Notice at <http://www.cms.gov/Medicare/Health-Plans/MedicareAdvtgSpecRateStats/Ratebooks-and-Supporting-Data.html>. Each county's applicable percentage is assigned based upon its quartile ranking, as follows:

Quartile	Applicable Percentage
4th (highest)	95%
3rd	100%
2nd	107.5%
1st (lowest)	115%

Section 1853(n)(2)(D) of the Act provides that, beginning in 2013, if there is a change in a county's quartile ranking for a payment year compared to the county's ranking in the previous year, the applicable percentage for the area for the year shall be the average of: 1) the applicable percentage for the previous year and 2) the applicable percentage for the current year. For both years, CMS will calculate the applicable percentage that would otherwise apply for the area for the year in the absence of this transitional provision. For example, if a county's ranking changed from the second quartile to the third quartile, the applicable percentage would be 103.75 percent for the year of the change – the average of 107.5 percent and 100 percent.

A3. Quality Bonus Payment Percentage

The ACA provides for CMS to make quality bonus payments to MA organizations that meet quality standards measured under a five-star quality rating system.

PERCENTAGE ADD-ON TO APPLICABLE PERCENTAGE FOR QUALITY BONUS PAYMENTS

Star Rating	2016 QBP Percentage*
Less than 3 stars	0%
3 stars	0%
3.5 stars	0%
4 stars	5%
4.5 stars	5%
5 stars	5%

A4. Qualifying County Bonus Payment

Beginning with payment year 2012, the Act extends a double QBP percentage to a qualifying plan located in a "qualifying

county.” The Act defines a qualifying county as a county that meets the following three criteria:

- has an MA capitation rate that, in 2004, was based on the amount specified in section 1853(c)(1)(B) for a Metropolitan Statistical Area with a population of more than 250,000;
- as of December 2009, had at least 25 percent of MA-eligible beneficiaries residing in the county enrolled in a MA plan; and
- has per capita FFS county spending for 2016 that is less than the national monthly per capita cost for FFS for 2016.

CMS will publish a complete list of qualifying counties in the final 2016 Announcement. The listing will contain all counties that meet all three criteria stated above. Two of the three elements for determining a qualifying county (2004 urban floors (Y/N for each county) and 2009 Medicare Advantage penetration rates can be found in the 2015 Rate Calculation Data file (columns W and X) on the CMS website at <http://www.cms.gov/Medicare/Health-Plans/MedicareAdvtgSpecRateStats/Ratebooks-and-Supporting-Data.html>. The 2016 FFS rates, which are necessary for the third criterion, are not available at the time this Advance Notice is published. The FFS rates and the national average FFS spending amount will be published in the final 2016 Announcement.

A5. Affordable Care Act County Rates Transitional Phase-In

The blend of the specified amount and applicable amount used to create the county rates is being phased in on a transitional basis. In 2012, each county was assigned to one of three transition periods - two, four, or six years. CMS determined a county’s specific transition period by calculating the difference

between the county’s Projected 2010 benchmark amount and 2010 applicable amount. The county transition period assigned is based on the size of the difference between these two amounts, with six-year counties having the largest differential (at least \$50). The projected 2010 benchmark amount was a one-time only calculation, which has been employed solely for the purpose of assigning each county its appropriate transition period, in accordance with the ACA.

A6. Blended Benchmark Calculations

For 2016, those counties with a six-year transition will have their rates based on 1/6 pre-ACA and 5/6 ACA values. All other counties will be based on 100 percent of the ACA rate.

A7. Cap on Blended Benchmarks

Section 1853(n)(4) of the Act requires that the blended benchmark for a county must be capped at the level of the county’s applicable amount at section 1853(k)(1) of the Act. This provision specifies that the QBP increase must be included in the blended benchmark before the comparison is made to determine if the cap is required. Thus, for all counties, rates are capped at the section 1853(k)(1) amount – that is, what the benchmark would have been under the pre-ACA rules.

A8. Rebate

Rebates are calculated, for each plan, as a percentage of the difference between the risk-adjusted service area benchmark and the risk-adjusted bid. Plans use rebates to fund supplemental benefits and/or to buy down beneficiary premiums.

Section B. Calculation of Fee for Service Rates

The FFS rate for each county is a product of 1) the national FFS cost, or United States per-capita cost, and 2) a county-level geographic index called the average geographic adjustment.

For 2016, CMS is proposing to update the claims data used to calculate the AGAs, and to continue the repricing of historical data in the AGA calculation.

B1. AGA Methodology for 2016

CMS is proposing to add the 2013 cost and enrollment data, and drop the 2008 cost and enrollment data, to the historical claims experience used to develop new geographic cost indices for each county. As a result, the five-year rolling average will be based on claims data from 2009-2013.

CMS will exclude hospice expenditures and FFS claims paid on behalf of cost plan enrollees from the 2013 claims. Comparable adjustments were previously made to 2009-2012 claims data. CMS will re-price the historical inpatient, hospital outpatient, skilled nursing facility, and home health claims from 2009 – 2013 to reflect the most current (i.e., FY 2015) wage indices, and re-tabulate physician claims with the most current (i.e., CY 2015) Geographic Practice Cost Index. For 2016, CMS will also continue to adjust historical FFS claims to account for Section 3133 of the ACA which replaced 75 percent of hospital Medicare Disproportional Share Hospital Payments with uncompensated care payments beginning on October 1, 2013.

Additional Adjustments

As in prior years, CMS will also make additional adjustments to the FFS rates for certain items. These adjustments are made after the AGA is calculated:

- Direct Graduate Medical Education: removed from FFS county rates (section 1853(c)(1)(D)(i) of the Act)
- Exclusions for Electronic Health Record incentives for doctors and hospitals (section 1853(c)(1)(D)(i) of the Act)
- Indirect Medical Education: removed from FFS county rates, as per phase-out schedule in MIPPA (section 1853(k)(4) of the Act)
- Credibility: for counties with less than 1,000 members, blend county experience with that of others in the market area
- VA-DOD: apply a cost ratio (an increase to claim costs) to counties with significant Tricare enrollment in the Uniformed Services Family Health Plan (section 1853(c)(1)(D)(iii) of the Act).

B2. Adjustment to FFS per Capita Costs for VA-DoD Costs

For CY 2016, CMS is proposing to update the VA-DoD adjustment using the same methodology first implemented in CY 2012, based on an analysis of more recent Medicare claims for DoD dual enrollees for calendar years 2008-2012. CMS will adjust the FFS rates by the ratios calculated. Based on applying the adjustments to the 2016 FFS rates, the average FFS rate will change in 179 affected counties by an average of \$1.16, with a range of a decrease of \$0.08 to an increase of \$20.74; 165 counties will experience increases in FFS rates of \$0.01 or more.

Section C. IME Phase Out

To help plans identify the impact, CMS will separately identify the amount of IME for each county rate in the 2016 ratebook. CMS will also publish the rates with and without the IME reduction for the year.

continued

Section D. ESRD Rates

The 2016 ESRD dialysis rates by state are determined by multiplying the 2016 FFS ESRD dialysis USPCC by the state AGA. The 2016 ESRD dialysis rate is adjusted by removing GME expenses and gradually removing the indirect medical education expenses.

Section E. Clinical Trials

In 2016, CMS will continue 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 relevant National Coverage Determinations on clinical trials.

Section F. Location of Network Areas for PFFS Plans in Plan Year 2017

CMS will include a list of network areas for plan year 2017 in the final Announcement of Calendar Year (CY) 2016 Medicare Advantage Capitation Rates and Medicare Advantage and Part D Payment Policies. CMS will also include the list on the CMS website at <http://www.cms.gov/Medicare/Health-Plans/PrivateFeeforServicePlans/NetworkRequirements.html>. CMS will use January 1, 2015 enrollment data to identify the location of network areas for plan year 2017.

Section G. CMS-HCC Risk Adjustment Model for CY 2016

For payment year 2016, CMS proposes to transition entirely to using risk scores calculated from the community, institutional, new enrollee, and C-SNP new enrollee segments of the clinically-revised CMS-HCC model in Part C payment for aged/disabled beneficiaries.

Section H. Medicare Advantage Coding Pattern Adjustment

For 2016, CMS proposes to update the MA coding adjustment factor to the statutory minimum of 5.41 percent.

Section I. Normalization Factors

When CMS calibrates a risk adjustment model, CMS produces a fixed set of dollar coefficients appropriate to the population and data for that calibration year. CMS sets the average risk score to 1.0 in the denominator year.

I1. Normalization for the CMS-HCC Model

The preliminary 2016 normalization factor for the model implemented in 2014 (V22) is: 0.992.

I2. Normalization Factor for the PACE Model

The preliminary 2016 normalization factor for the CMS-HCC risk adjustment model used for the PACE program is 1.042.

I3. Normalization Factor for the ESRD Dialysis Model

The preliminary 2016 normalization factor for the ESRD dialysis model is 0.990.

I4. Normalization Factor for Functioning Graft Model

The preliminary 2016 normalization factor for the Functioning Graft segment of the ESRD risk adjustment model is 1.042.

I5. Normalization Factor for the Rx Hierarchical Condition Category (RxHCC) Model

The preliminary 2016 normalization factor for the RxHCC model is 0.939.

Section J. Frailty Adjustment for PACE Organizations and FIDE SNPs

The frailty factors for PACE organizations will not change for FY 2016; the same frailty factors used in 2015 for PACE organizations will be used. These can be found in the 2012 Announcement in Attachment VI, Table 13, at <http://www.cms.gov/Medicare/Health-Plans/MedicareAdvtgSpecRateStats/Announcements-and-Documents.html>.

Section K. Medical Loss Ratio Credibility Adjustment

For CY 2016, CMS is not proposing any changes to the credibility adjustments.

Section L. International Classification of Diseases-10 (ICD-10) Code Set

CMS proposes that the data collection year for risk scores used for 2016 payment would use diagnoses from the prior calendar year (CY 2015). Thus, both ICD-9 codes (from dates of service January 1, 2015 – September 30, 2015) and ICD-10 codes (from dates of service October 1, 2015 – December 31, 2015) would be used in calculating 2016 risk scores.

Section M. Encounter Data as a Diagnosis Source for 2016

CMS proposes to calculate the 2016 risk score by blending two risk scores calculated as follows: one risk score calculated using diagnoses with dates of service of 2015 from RAPS and FFS and another separate risk score using diagnoses with dates of service 2015 from EDS and FFS. CMS will blend the two risk scores, weighting the risk score from RAPS and FFS by 90 percent and the risk score from EDS and FFS by 10 percent. For PACE organizations, CMS proposes to continue the same method of calculating risk scores as used for the 2015 payment

year, which is to use diagnoses from the following sources in equal measure (with no weighting): (1) Encounter Data System data valid for risk adjustment with 2015 dates of service; (2) Risk Adjustment Processing System (RAPS) data valid for risk adjustment with 2015 dates of service; and (3) Diagnoses from FFS claims valid for risk adjustment.

ATTACHMENT III. CHANGES IN THE PAYMENT METHODOLOGY FOR MEDICARE PART D FOR CY 2016

Section A. Update of the RxHCC Model

For 2016, CMS is proposing to implement an updated version of the RxHCC risk adjustment model used to adjust direct subsidy payments for Part D benefits offered by stand-alone Prescription Drug Plans (PDPs) and Medicare Advantage-Prescription Drug Plans (MA-PDs).

A1. Update to Reflect the 2016 Benefit Structure

CMS recalibrated the RxHCC risk adjustment model to reflect the 2016 benefit structure. This update involves making adjustments to the Prescription Drug Event (PDE) data from the prediction year to approximate the 2016 benefit structure.

A2. Update to the Data Years Used to Calibrate the Model

The current model is calibrated on 2010 diagnoses and 2011 expenditure data from the PDE records. As part of this recalibration for 2016, CMS has updated the underlying data, using diagnosis data from 2012 fee-for-service claims and MA-PD RAPS files, along with 2013 expenditure data from PDE records.

A3. Clinical Update to the Diagnoses Included in Some Prescription Drug Hierarchical Condition Categories (RxHCCs)

Preliminary 2016 payment year diagnosis code to 2016 RxHCC model mappings will be posted on the CMS Risk Adjustment Webpage, <http://www.cms.gov/Medicare/Health-Plans/MedicareAdvtgSpecRateStats/Risk-Adjustors.html?DLSort=0&DLPage=1&DLSortDir=descending>.

A4. Inclusion of MA-PD Data in the Model Calibration

To recalibrate the model for payment year 2016, diagnoses from FFS and MA-PD beneficiaries enrolled in a Part D plan were used; 2012 diagnoses were used to predict 2013 expenditures. To be included in the model estimation sample, beneficiaries must be: (1) FFS or Medicare Advantage (MA-PD or MA-only) for all 12 months of the base year (2012); and (2) enrolled in a PDP or an MA-PD for at least one month in the payment year (2013).

A5. Actuarial Adjustment to the Chronic Viral Hepatitis C RxHCC

To capture the substantial cost of these medications that are expected in the payment year, CMS applied an actuarial adjustment to the coefficient of the new chronic Hepatitis C RxHCC.

A6. Recalibration

In Attachment V of this Notice, CMS provides draft factors for each RxHCC for each segment of the model.

Section B. International Classification of Diseases-10 (ICD-10) Code Set and Diagnosis Data Sources for 2016 Risk Scores

Both ICD-9 codes (from dates of service January 1, 2015 – September 30, 2015) and ICD-10 codes (from dates of service

October 1, 2015 – December 31, 2015) would be used in calculating 2016 risk scores.

Section C. Encounter Data as a Diagnosis Source for 2016

CMS proposes to calculate the 2016 risk score by blending two risk scores calculated as follows: one risk score calculated using diagnoses with dates of service of 2015 from RAPS and FFS and another separate risk score using diagnoses with dates of service 2015 from EDS and FFS.

Section D. Payment Reconciliation

The risk percentages and payment adjustments for Part D risk sharing are unchanged from contract year 2015. The risk percentages for the first and second thresholds remain at 5 percent and 10 percent of the target amount, respectively, for 2016. The payment adjustments for the first and second corridors are 50 percent and 80 percent, respectively (Figure 1).

D1. Risk Sharing When a Plan's Adjusted Allowable Risk Corridor Costs Exceed the Target Amount

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

D2. Risk Sharing When a Plan's Adjusted Allowable Risk Corridor Costs Are Below the Target Amount

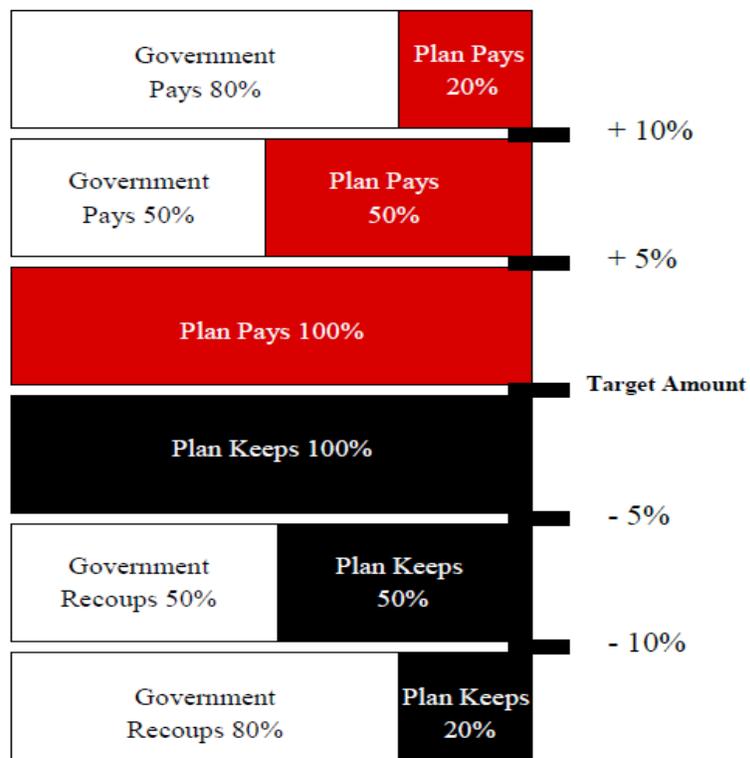
If a plan's AARCC is between the target amount and the first threshold lower limit (95 percent of the target amount), the plan keeps 100 percent of the difference between the target amount and the plan's AARCC. If a plan's AARCC is between the first threshold lower limit and the second threshold lower limit (90 percent of the target amount), the government recoups 50 percent of the difference between the first threshold lower limit and the plan's AARCC. The plan would keep 50 percent of the difference between the first threshold lower limit and the plan's AARCC as well as 100 percent of the difference between the target amount and first threshold lower limit. If a plan's AARCC is less than the second threshold lower limit, the government recoups 80 percent of the difference between the plan's AARCC and the second threshold lower

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

Section E. Medicare Part D Benefit Parameters: Annual Adjustments for Defined Standard Benefit in 2016

In accordance with section 1860D-2(b) of the Act, CMS must update the statutory parameters for the defined standard Part D prescription drug benefit each year. These parameters include the annual deductible, initial coverage limit, annual out-of-pocket threshold, and minimum copayments for costs above the annual out-of-pocket threshold. As required by statute, the parameters for

Figure 1. Part D Risk Corridors for 2016



continued

the defined standard benefit are indexed to the percentage increase in average per capita total Part D drug expenses for Medicare beneficiaries.

UPDATED PART D BENEFIT PARAMETERS FOR DEFINED STANDARD BENEFIT, LOW-INCOME SUBSIDY, AND RETIREE DRUG SUBSIDY

Annual Percentage Increases

	Annual percentage trend for 2015	Prior year revisions	Annual percentage increase for 2015
Applied to all parameters but (1)	6.37%	5.07%	11.76%
CPI (all items, U.S. city average): Applied to (1)	1.45%	0.17%	1.62%

Part D Benefit Parameters

	2015	2016
Standard Benefit		
Deductible	\$320	\$360
Initial Coverage Limit	\$2,960	\$3,310
Out-of-Pocket Threshold	\$4,700	\$4,850
Total Covered Part D Spending at Out-of-Pocket Threshold for Non-Applicable Beneficiaries (2)	\$6,680.00	\$7,062.50
Estimated Total Covered Part D Spending for Applicable Beneficiaries (3)	\$7,061.76	\$7,515.22
Minimum Cost-Sharing in Catastrophic Coverage Portion of the Benefit		
Generic/Preferred Multi-Source Drug	\$2.65	\$2.95
Other	\$6.60	\$7.40
Full Subsidy-Full Benefit Dual Eligible Individuals (5)		
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)	\$0.00	\$0.00
Maximum Copayments for Non-Institutionalized Beneficiaries		
Up to or at 100% FPL (category code 2)		
Up to Out-of-Pocket Threshold (1)		
Generic/Preferred Multi-Source Drug (4)	\$1.20	\$1.20
Other (4)	\$3.60	\$3.60
Above Out-of-Pocket Threshold	\$0.00	\$0.00
Over 100% FPL (category code 1)		
Up to Out-of-Pocket Threshold		
Generic/Preferred Multi-Source Drug	\$2.65	\$2.95
Other	\$6.60	\$7.40
Above Out-of-Pocket Threshold	\$0.00	\$0.00

Partial Subsidy		
Applied and income below 150% FPL and resources below \$13,640 (individual) or \$27,250 (couples) (6)		
Deductible	\$66.00	\$74.00
Coinsurance up to Out-of-Pocket Threshold	15%	15%
Maximum Copayments above Out-of-Pocket Threshold		
Generic/Preferred Multi-Source Drug	\$2.65	\$2.95
Other	\$6.60	\$7.40
Retiree Drug Subsidy Amounts		
Cost Threshold	\$320	\$360
Cost Limit	\$6,600	\$7,400

(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 are not eligible for the coverage gap program, this is the amount of total drug spending required to reach the out-of-pocket threshold in the defined standard benefit. Enhanced alternative plans must use this value when mapping enhanced alternative plans to the defined standard benefit for the purpose of calculating covered plan paid amounts reported on prescription drug event records.

(3) For beneficiaries who are considered an “applicable beneficiary” as defined at section 1860D-14A(g)(1) and are eligible for the coverage gap discount program, this is the estimated average amount of total drug spending required to reach the out-of-pocket threshold in the defined standard benefit. Enhanced alternative plans must use this value when mapping enhanced alternative plans to the defined standard benefit for the purpose of calculating covered plan paid amounts reported on prescription drug event records.

(4) Per section 1860D-14(a)(1)(D)(i), full-benefit dual eligibles who would be institutionalized individuals (or couple) if the individual (couple) was not receiving home and community-based services qualify for zero cost-sharing as of January 1, 2015, as specified by the Secretary.

(5) The increases to the LIS deductible, generic/preferred multi-source drugs and other drugs copayments are applied to the unrounded 2015 values of \$66.03, \$1.20, and \$3.59, respectively.

(6) The actual amount of resources allowable will be updated for contract year 20

Section F. Reduced Coinsurance for Applicable Beneficiaries in the Coverage Gap

In 2016, the coinsurance under basic prescription drug coverage for certain beneficiaries is further reduced from 2015 for non-applicable covered Part D drugs purchased during the coverage gap phase of the Part D benefit. The coinsurance charged to eligible beneficiaries will be equal to 58 percent. Also in 2016, the coinsurance under basic prescription drug coverage for certain beneficiaries is reduced for applicable covered Part D drugs purchased during the coverage gap phase of the Part D benefit.

Section G. Dispensing Fees and Vaccine Administration Fees for Applicable Drugs in the Coverage Gap

In 2016, applicable beneficiaries will pay 45 percent and plans will pay 55 percent of dispensing fees and vaccine administration fees for applicable drugs in the coverage gap.

ATTACHMENT IV. MEDICARE PART D BENEFIT PARAMETERS FOR THE DEFINED STANDARD BENEFIT: ANNUAL ADJUSTMENTS FOR 2016

Section A. Annual Percentage Increase in Average Expenditures for Part D Drugs Per Eligible Beneficiary

The following parameters are updated using the “annual percentage increase”:

- Deductible: From \$320 in 2015 and rounded to the nearest multiple of \$5.
- Initial Coverage Limit: From \$2,960 in 2015 and rounded to the nearest multiple of \$10.
- Out-of-Pocket Threshold: From \$4,700 in 2015 and rounded to the nearest multiple of \$50. The “annual percentage increase” applied to the out-of-pocket threshold is $CPI+2\%$ which is the lesser of API and $CPI+2\%$ as required by the ACA.
- Minimum Cost-Sharing in the Catastrophic Coverage Portion of the Benefit: From \$2.65 per generic or preferred drug that is a multi-source drug, and \$6.60 for all other drugs in 2015, 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 \$2.65 per generic or preferred drug that is a multi-source drug, and \$6.60 for all other drugs in 2015, and rounded to the nearest multiple of \$0.05.
- Deductible for Low Income (Partial) Subsidy Eligible Enrollees: From \$666 in 2015 and rounded to the nearest \$1.
- Maximum Copayments above the Out-of-Pocket Threshold for Low Income (Partial) Subsidy Eligible Enrollees: From \$2.65 per generic or preferred drug that is a multi-source drug, and \$6.60 for all other drugs

in 2015, and rounded to the nearest multiple of \$0.05.

Section B. Annual Percentage Increase in Consumer Price Index, All Urban Consumers (all items, U.S. city average)

Copayments are increased from \$1.20 per generic or preferred drug that is a multi-source drug, and \$3.60 for all other drugs in 2015, and rounded to the nearest multiple of \$0.05 and \$0.10, respectively.

ATTACHMENT V. PRELIMINARY RxHCC RISK ADJUSTMENT FACTORS

This attachment contains several tables as follows:

- Table 1. Preliminary RxHCC Model Relative Factors for Continuing Enrollees
- Table 2. Preliminary RxHCC Model Relative Factors for New Enrollees, Non-Low Income
- Table 3. Preliminary RxHCC Model Relative Factors for New Enrollees, Low Income
- Table 4. Preliminary RxHCC Model Relative Factors for New Enrollees, Institutional
- Table 5. Preliminary List of Disease Hierarchies for the Proposed RxHCC Model
- Table 6. Comparison of Current and Proposed RxHCC Risk Adjustment Model RxHCCs

ATTACHMENT VI: 2016 DRAFT CALL LETTER

The 2016 Call Letter contains information on the Part C and Part D programs that Medicare Advantage Organizations and Part D sponsors need to take into consideration in preparing their 2016 bids. Guidance on Medicare-Medicaid Plan-specific requirements will be released in early 2015.

continued

CMS is proposing to further align the Medicare Advantage and Part D programs with those goals.

- Higher Quality of Care – The 2016 Draft Call Letter includes a number of updates to the star rating system used to assess the performance of plans in providing enrollees with high quality care. The proposed updates would strengthen the accuracy of the evaluation system, as well as to improve incentives for plans to provide care for dual eligible or low-income beneficiaries.
- More Information for Enrollees – The 2016 Draft Call Letter proposes to improve the information available to beneficiaries regarding plan networks, including an emphasis on requirements for plans to maintain accurate provider directories for beneficiaries.
- Payment reform – The 2016 Draft Call Letter announces CMS's intention to work with plans to collect information on the adoption of valued-based payment models among health plans.

*Analysis provided for MHA
by Larry Goldberg,
Goldberg Consulting*