February 22, 2008

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

SUBJECT: Advance Notice of Methodological Changes for Calendar Year (CY) 2009 for Medicare Advantage (MA) Capitation Rates and Part D Payment Policies

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 2009. Preliminary estimates of the national per capita MA growth percentage and other MA payment methodology changes for CY 2009 are also discussed. For 2009, CMS will announce the MA capitation rates on the first Monday in April 2008, 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.

Attachment I shows the preliminary estimates of the national per capita MA growth percentage component of the minimum percentage increase, which is a key factor is determining the MA capitation rates. Attachment II sets forth the changes in payment methodology for CY 2009 for original Medicare benefits. Attachment III set forth the changes in payment methodology for CY 2009 for Part D benefits. Attachment IV presents the preliminary CMS-HCC risk adjustment factors, and Attachment V presents the annual adjustments for 2009 to the Medicare Part D benefit parameters for the defined standard benefit.

Any changes to employer/union-only group waiver plan payment for 2009 will be issued in future guidance.

Comments or questions may be submitted electronically to the following address: AdvanceNotice2009@cms.hhs.gov. Comments or questions also may be mailed to:

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In order to receive consideration prior to the April 7, 2008 release of the Announcement of Calendar Year (CY) 2009 Medicare Advantage Capitation Rates and Medicare Advantage and Part D Payment Policies, comments must be received by 6:00 PM EST on Friday, March 7, 2008.

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Attachments

2009 ADVANCE NOTICE
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Attachment I. Preliminary Estimate of the National Per Capita Growth Percentage for Calendar Year 2009

Section 1853(c)(1) of the Social Security Act (the Act) provides that, for years when CMS is "rebasing" the amount representing the actuarial value of 100 percent of costs under original fee-for-service (FFS) Medicare, MA capitation 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 national per capita MA growth percentage, with no adjustment to this percentage for over- or under-estimates for years before 2004. CMS is rebasing the FFS rates for 2009. See section J, Attachment II for a discussion of the proposed methodology for adjusting the FFS rates to reflect DOD and VA costs, per Section 1853(c)(1)(D)(iii) of the Act.

The current estimate of the change in the national per capita MA growth percentage for aged and disabled enrollees combined in CY 2009 is 4.8 percent. This estimate reflects an underlying trend change for CY 2009 in per capita costs of 3.4 percent and adjustments to the estimates for CY 2008, CY 2007, CY 2006, CY 2005, and CY 2004 aged and disabled MA growth percentages of 2.4 percent, –0.9 percent, 0.1 percent, –0.3 percent, and 0.2 percent, respectively. Our new estimates for these years are lower than the estimates actually used in calculating the CY 2008 capitation rate book for CYs 2005 and 2007 and higher for CYs 2004, 2006, and 2008 than was published April 2, 2007, 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 MA Growth Percentage

	Aged	Disabled	ESRD	Aged+Disabled
2009 Trend Change	3.4%	3.4%	1.6%	3.4%
Revision to CY 2008 Estimate	1.8%	5.7%	2.9%	2.4%
Revision to CY 2007 Estimate	–1.1%	0.2%	–3.2%	–0.9%
Revision to CY 2006 Estimate	0.3%	–1.3%	–5.1%	0.1%
Revision to CY 2005 Estimate	–0.2%	–1.2%	–1.8%	–0.3%
Revision to CY 2004 Estimate	0.2%	0.2%	–0.2%	0.2%
Total Change	4.5%	7.0%	–5.9%	4.8%

Notes: (1) The total percentage change is multiplicative, not additive and may not exactly match due to rounding.
(2) Starting in 2008, the trend change for ESRD reflects an estimate of the trend for dialysis-only beneficiaries.

These estimates are preliminary and could change before the final rates are announced on April 7, 2008 in the Announcement of Calendar Year (CY) 2009 Medicare Advantage Capitation Rates and Medicare Advantage and Part D Payment Policies. Further details on the derivation of the national per capita MA growth percentage will also be presented in the Announcement.

Attachment II. Changes in the Payment Methodology for Original Medicare Benefits for CY 2009

Section A. Recalibration of CMS-HCC Model

In 2009, CMS will implement an updated version of the aged-disabled CMS-HCC risk adjustment model, including community, institutional, and new enrollee segments of the model. Fee-for-service (FFS) claims data for the years 2004 and 2005 are used in the recalibration of the model. Disease groupings are the same as in past models; however, the factors are different.

When CMS recalibrates the CMS-HCC risk adjustment model with more recent data, an updated coefficient is calculated for each diagnosis group and demographic characteristic in the model (e.g., age, sex), which represents the marginal (additional) cost of that diagnosis group or demographic characteristic in predicting FFS per capita costs. These coefficients are then converted to relative cost factors by dividing each by the per capita cost predicted for a specific year. For the CY 2009 recalibration, CMS used predicted per capita costs for 2007. The relative factors are used to calculate risk scores for individual beneficiaries, which will average 1.0 in the denominator year.

The current CMS-HCC model is calibrated on 2002 and 2003 data, and recalibrating the model on more current data results in more appropriate relative weights for each HCC because they reflect more recent coding and expenditure patterns in FFS Medicare. In addition, recalibrating with more recent data adjusts the model for increases in predicted FFS expenditures between calibration years. Recalibration of the CMS-HCC model can result in changes in relative risk scores for individual beneficiaries and for average plan risk scores, depending on individual beneficiaries' combinations of diagnoses.

One change that was made to the model was to remove the constraints on two HCCs: Metastatic Cancer (HCC 7) and Severe Cancers (HCC 8). In the version of the model currently in use, the coefficients of HCC 7 (Metastatic Cancer) and HCC 8 (Severe Cancers) were constrained to be equal. In the past, these HCCs were constrained because there were concerns regarding the completeness of the coding for Metastatic Cancer, specifically that secondary (metastatic) cancers were sometimes incorrectly coded as primary cancers.

With the constraint removed, the estimated incremental cost of Metastatic Cancer (HCC 7) is now higher than that for Severe Cancers (HCC 8). CMS determined that there was significant clinical and expected treatment cost difference between metastatic and localized cancer (e.g., chemotherapy for metastatic cancer). Although current coding may be imperfect, there are specific diagnostic tests and indications for metastatic versus localized cancers, and allowing a payment differential will provide incentives for accurate coding. More importantly, a higher incremental payment for beneficiaries with metastatic cancer will provide for more accurate payment to Medicare Advantage plans that enroll such beneficiaries.

In Attachment IV of this Notice, we provide the relative cost factors for each HCC for each segment of the aged-disabled model.

Section B. Frailty Adjustment

B1. Frailty Adjustment Factors

CMS has recalibrated the frailty factors for CY 2009. The purpose of frailty adjustment is to predict the Medicare expenditures of community populations with functional impairments that are unexplained by the CMS-HCC risk adjustment model. Whenever CMS recalibrates the CMS-HCC risk adjustment model, the amount of unexplained Medicare expenditures can change. Thus, it is necessary to simultaneously recalibrate the frailty factors. Table II-1 presents the preliminary recalibrated frailty factors for CY 2009.

Table II-1. Preliminary Recalibrated Frailty Factors for CY 2009

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

CMS is not proposing to change the way we calculate the contract-level frailty score; we will use the results from each contract's 2008 HOS survey to calculate each contract-level frailty score for CY 2009.

B2. Frailty Adjustment Transition for PACE organizations

Frailty adjustment factors will be applied to payment to PACE organizations using the transition schedule published in the 2008 Announcement (published April 2, 2007). PACE frailty scores for payment year 2009 will be calculated at a blend of 70% of the frailty factors in use prior to 2008 and 30% of the recalibrated frailty factors implemented in 2009. The full transition schedule is as follows:

- In 2008 (year 1): 90% of the pre-2008 frailty factors and 10% of the 2008 frailty factors.
- In 2009 (year 2): 70% of the pre-2008 frailty factors and 30% of the 2009 frailty factors.
- In 2010 (year 3): 50% of the pre-2008 frailty factors and 50% of the most recently calibrated frailty factors.
- In 2011 (year 4): 25% of the pre-2008 frailty factors and 75% of the most recently calibrated frailty factors.
- In 2012 (year 5): 100% of the most recently calibrated frailty factors.

B3. Frailty Adjustment Transition for Certain Demonstrations

Frailty adjustment factors will be applied to payment to the following MA plan types using the phase-out schedule published in the 2008 Announcement (published April 2, 2007): Social Health Maintenance Organizations (S/HMOs), Minnesota Senior Health Options (MSHO)/ Minnesota Disability Health Options (MnDHO), Wisconsin Partnership Program (WPP) and Massachusetts Senior Care Options (SCO) plans.

The full phase out schedule is as follows:

- In 2008 (year 1): 75% of the pre-2008 frailty factors
- In 2009 (year 2) 50% of the pre-2008 frailty factors
- In 2010 (year 3) 25% of the pre-2008 frailty factors
- In 2011, 0% of the pre-2008 frailty factors

Section C. Normalization Factors

When we calibrate a risk adjustment model and normalize the risk scores to 1.0, we produce a fixed set of dollar expenditures and coefficients appropriate to the population and data for that calibration year. When the model with fixed coefficients is used to predict expenditures for other years, predictions for prior years are lower and predictions for succeeding years are higher than for the calibration year. Because average predicted fee-for-service (FFS) expenditures increase after the model calibration year due to coding and population changes, CMS applies a normalization factor to adjust beneficiaries' risk scores so that the average risk score is 1.0 in subsequent years.

The normalization factor is derived by first using the model to predict risk scores for the FFS population over a number of years. Next, we trend the risk scores to determine the annual percent change in the risk score. This amount is then compounded by the number of years between the model denominator year and the payment year to produce the normalization factor.

Starting in 2009, CMS will use a standard of five years of data in the normalization trend. Each year, CMS will drop the earliest year and add a new year of risk scores to the trend data to create the five-year dataset. By using a standard number of years, CMS intends to calculate risk score trends based on recent trends in coding, while maintaining stability in the year-to-year trends used. For the CY 2009 recalibration, trends calculated for the aged-disabled CMS-HCC, ESRD Dialysis, and the RxHCC models are developed on risk scores calculated for 2003-2007.

Below are the preliminary normalization factors for each model. The final normalization factors will be included in the April 7, 2008 Announcement.

C1. Normalization Factor for the CMS-HCC Model

The preliminary 2009 normalization factor for the aged-disabled model is 1.030. The 2009 factor will adjust for two years of FFS risk score growth, i.e., from the denominator year of 2007 to the payment year of 2009. This 2009 normalization factor of 1.030 is lower than the 2008 factor of 1.04 because the 2008 factor adjusted for three years of FFS risk score growth (2005-2008).

C2. Normalization Factor for the ESRD Dialysis Model

The preliminary 2009 normalization factor for the ESRD dialysis model is 1.019. The 2009 factor will adjust for six years of risk score growth, i.e., from the denominator year of 2003 to the payment year of 2009, and will be applied at a phased-in percentage of 50%. (As discussed in last year's Advance Notice, the ESRD Dialysis normalization factor is being applied on the same transition schedule as is the transition of the ESRD State ratebook; see Section G2.)

C3. Normalization Factor for the RxHCC Model

The preliminary 2009 normalization factor for the RxHCC model is 1.085. This normalization factor reflects a trend calculated on five years of risk score data (2003-2007). We calculated the RxHCC normalization factor by taking the actual 2007 average Part D risk score for all potential Part D plan enrollees and the annual trend applied for the two years between the calculation of actual average Part D risk score and the payment year (2007-2009).

C4. Normalization Factor for Functioning Graft Enrollees' Risk Scores

CMS applies the normalization factor for the aged-disabled CMS-HCC model to Functioning Graft enrollees' risk scores because all but one of the coefficients for the Functioning Graft model are constrained to equal the coefficients of the CMS-HCC model, and because CMS pays for Functioning Graft enrollees using the county ratebook. However, because CMS recalibrates the functioning graft coefficients along with the dialysis model, the functioning graft coefficients still have a denominator of 2005 (instead of the 2007 denominator that the CMS-HCC community and institutional coefficients will have in 2009). For that reason, CMS will add an additional year to the 2008 CMS-HCC normalization factor; the preliminary 2009 normalization factor to be applied to the 2009 risk scores of enrollees in functioning graft status is 1.058.

Section D. Budget Neutrality

From 2003 through 2006, CMS implemented risk adjusted payments in a budget neutral manner by applying to the risk rates 100 percent of the Budget Neutrality (BN) factor, which is calculated as the estimated difference between payments to MA organizations at 100 percent of the demographic rates and payments at 100 percent of the risk rates. As previously announced by CMS on February 17, 2006 in the Advance Notice for 2007, and as summarized below, the phase-out of budget-neutral risk adjusted payments began in 2007 and will be completed by 2011, when plans will receive no budget neutrality payment adjustment. For 2009, 25 percent of the BN factor will be applied to the risk rates.

Since CMS cannot calculate the BN factor until the final capitation rates are determined, the factor will be announced in the April 7, 2008 Rate Announcement.

Phase-out Schedule for Budget Neutral Risk Adjusted Payments:

The percentage of the budget neutrality factor that is applied to the risk rates is:

- 2007: 55%
- 2008: 40%
- 2009: 25%
- 2010: 5%
- 2011: 0%

Section E. Adjustment for MA Coding Intensity

Background

As promulgated by the Deficit Reduction Act (DRA), Section 1853(k)(2)(B)(iv)(III) requires CMS to reflect in its risk adjustment for Part C payment "differences in coding patterns between Medicare Advantage plans and providers under part A and B to the extent that the Secretary has identified such differences." The DRA further instructs that results of the analysis will be "incorporated into the risk scores only for 2008, 2009, and 2010." In order to comply with this section of the DRA, CMS has studied the changes in MA and FFS risk scores, the differences between those changes, and the coding patterns behind these changes.

From our research for the 2008 payment year, CMS found that MA risk scores increased approximately twice as much as FFS risk scores did for our study population between 2004 and 2006. There are a number of key reasons why risk scores in the MA and FFS sectors may rise at different rates. The composition of enrollment in each sector can have an effect on the change in the average risk score. Initially, some MA plans may have had difficulty gathering and reporting diagnosis codes as completely as FFS, so part of the differential risk score growth could be due to "catching up" to FFS. MA plans may be finding and diagnosing disease at a higher rate than FFS providers. Or, it is possible that beneficiaries enrolled in MA plans may be getting sicker faster than beneficiaries in FFS.

Our preliminary research on coding patterns, which was conducted prior to the release of the 2008 Rate Announcement, was unable to clarify enough about the coding pattern differences that result in MA and FFS risk score differences. Therefore, we did not make an adjustment for coding patterns differences in payment year 2008. We stated that we would continue to study this issue, with particular focus on the plans that have experienced significant increases in risk scores, in an effort to determine what the appropriate adjustment might be for 2009 and 2010.

CMS has continued its analysis of the coding patterns that result in differences in the MA and FFS risk scores. The findings below are based on diagnoses reported for payment years 2004-2006. CMS will update these figures by adding the (currently unavailable) 2007 risk scores to the analysis, prior to the publication of the Announcement on April 7, 2008.

Study Results

Composition effects: In order to analyze the gross difference between the change in FFS and MA risk scores, we examined the change in risk scores for three categories of enrollees: stayers, leavers, and joiners. **Stayers** were those enrollees who remained in the same sector (either FFS or MA) over the study period, **leavers** were those who left either the MA or FFS sector, either to go to the other sector or who died, and **joiners** where those who came into FFS or MA, either from the other sector or who were newly eligible to Medicare. We found that indeed some of the difference in the change in risk scores between MA and FFS was due to composition effects. Specifically, we found that:

- A significant portion of the beneficiaries who join MA are beneficiaries who are switching from FFS. In FFS, the vast majority of beneficiaries who join are newly-eligible to Medicare. The risk scores of beneficiaries who are newly eligible to Medicare

tend to be very low and these low risk scores depress FFS risk score growth relative to MA.
- Of the leavers, decedents (who have high risk scores) are a slightly larger fraction of FFS beneficiaries than of MA enrollees and, thus, the exit of high-risk score decedents restrains the year-to-year growth of average FFS risk scores by slightly more than it does MA scores.

Because most new enrollees in FFS are newly-eligible to Medicare and FFS is losing higher risk beneficiaries, overall average MA risk scores are pushed up at a faster rate than risk scores in FFS. Over the two-year period, approximately 50% of the difference between the MA and FFS sectors in the growth of risk scores is due to enrollment patterns and approximately 50% is due to the more rapid growth in risk scores for beneficiaries who stay in the same sector in consecutive years.

Focus on "stayers:" Focusing on the stayers allows us to examine differences in risk score changes that are not due to the changing composition of the enrolled population. In our analyses of the impact of coding patterns on stayers' risk scores, we did the following:

- We focused on two cohorts of stayers: those who were stayers in 2004-2005, and those who were stayers in 2005-2006. We weren't able to add the 2006-2007 cohort to the analysis prior to the release of the Advance Notice, but will do so before the release of the Announcement in April 2008.
- For each cohort, we defined MA stayers as those enrollees who were in the same contract in the July of each cohort year, as well as in each data collection year. For example, for the 2004-2005 stayer cohort, we include enrollees who were in the same contract in July 2004 and July 2005, and in all of 2003 and 2004. This criterion resulted in the exclusion of enrollees who would have been new enrollees in the data collection years, as well as those enrollees who switched contracts.
- We found that the overall risk scores of MA stayers increased by 0.032 more than those of FFS stayers over the two-year study period. As discussed below, we then broke down the change in aggregate risk scores into the changes in the disease component of the CMS-HCC risk score (the "disease score") versus the demographic component.

Focus on the disease score of stayers: The disease score is the HCC component of the risk score that plans (and FFS providers) affect by their reporting of diagnosis codes. Among stayers, we found that MA disease scores increased more quickly than FFS disease scores and that change in the disease component of the risk score accounted for approximately 90% of the difference in the change in MA versus FFS risk scores.

We found that, on average, disease scores for stayers in MA plans increased 20% faster than stayers in FFS over the two years in the study period. Specifically, FFS disease scores for stayers increased by 0.145 over the two-year period between 2004 and 2006, while the average disease score among beneficiaries who remained enrolled in a single MA contract for at least two data collection years increased by 0.174 over the same time period for a two-year difference of 0.029.

Dynamics behind changes in disease scores: CMS also analyzed the reasons why the change in MA and FFS disease scores differed among stayers. A significant portion of the difference in

disease score changes is attributable to the reporting of 26 HCCs (of the 70 HCCs in the model) that fall into one of seven hierarchies: diabetes (5 HCCs), cardiovascular disease (4 HCCs), coronary artery disease (3 HCCs), cancer (4 HCCs), quadriplegia and other central nervous system disease (4 HCCs), liver disease (3 HCCs), and dialysis/renal disease (3 HCCs). Approximately one-third of the difference in disease score change is due to increases in severity within these hierarchies, particularly within the diabetes hierarchy. The remaining difference results primarily from greater retention of reported diagnosis codes within certain hierarchies from one year to the next, especially the coronary artery disease, liver, diabetes, and renal hierarchies.

Variation among contracts: CMS research has also revealed a large amount of variation among MA contracts in the disease score change among stayers, and in the dynamics behind contracts' changing disease scores. As described above, on average, disease scores for MA stayers increased by 0.174 over the 2004-2006 study period, or 0.029 greater than the average increase of 0.145 for FFS stayers. We found that approximately 40% of the contracts in our study – those operating continuously during the 2004, 2005, and 2006 payment years – had changes in stayer disease scores that were less than the changes in FFS stayers' disease scores. Looking at enrollees, we found that 25% of the MA stayers in our analysis were enrolled in contracts where the difference between the two-year increase in stayers' disease scores and the FFS increase was at least twice the industry average.

Catch-up to FFS levels of coding: Although CMS cannot definitely determine whether "catch up" to FFS coding occurred or not, CMS recognizes that plans may have experienced some catch up, particularly during initial years of operation. In order to take any such catch up into account in our adjustment, we are proposing to:

- Adjust for MA coding only in 2009 and later (not adjust for previous year's coding patterns differences).
- Make an adjustment for contracts that have existed since at least 2005.
- Adjust risk scores for enrollees in contracts that have significant coding pattern differences from FFS.
- We are proposing to weight the impact of coding differences on disease scores in more recent years (when plans would have caught up to FFS) differently than coding patterns differences in earlier years.

More complete coding: We do not assume that the coding pattern differences that we found in our study are the result of improper coding. As discussed above, CMS understands that MA plans have made efforts to identify enrollees' conditions and may be coding more completely than FFS. However, because MA coding patterns differ from FFS coding patterns, the normalization factor (which is calculated based on FFS coding) does not currently adjust for these different coding patterns.

Impact of health status on risk score changes: As noted above, it is possible that beneficiaries enrolled in MA plans may be getting sicker faster than beneficiaries in FFS and this could be driving faster risk score growth for MA enrollees. Given the care coordination and disease management activities of MA plans, however, we do not find it reasonable to assume that MA stayers' underlying health status is getting worse at a faster rate than stayers in FFS. CMS analysis has found that MA mortality rates during the study period do not explain rising risk

scores; when applying expected mortality rates to the MA population, risk scores are expected to decrease, not increase. (In our analysis, we adjusted mortality rates for age, sex, county, Medicaid status, and institutional status.)

Calculation and Application of a Coding Intensity Measure

While our research supports the finding that MA plans have coding patterns that differ from FFS, we only have a few years to observe the differences in MA and FFS coding patterns. Therefore, for 2009 we propose to apply an MA coding adjustment factor as follows:

- Apply an adjustment to the risk scores of enrollees in those contracts for which the difference between the change in stayers' disease scores and the change in the FFS stayers' disease scores is two or more times the industry average; this threshold is approximately the same as a threshold at the plans enrolling the 25% of MA stayers with the largest change in disease score. We considered a few other options for applying an adjustment:
  - We considered applying an adjustment to those contracts above two standard deviations above the mean difference in disease score change, but the variation among plans is so great that such a threshold would eliminate most contracts.
  - We considered applying an adjustment on a contract-by-contract basis, but decided instead to apply a relatively high threshold in order to focus on the contracts that have experienced the largest changes in their stayers' disease scores, relative to FFS stayers' disease scores.

  CMS is requesting comments on the criteria for determining the threshold used to determine those contracts' payment to which we would apply an adjustment factor.

- Exclude those contracts that were not in existence until after 2005 (came into existence in 2006 or later). Contracts that existed in 2005 and earlier have at least two years of experience reporting to CMS stayers' diagnosis codes that have been used to calculate risk scores.

- Exclude contracts with under an average of 1,000 enrollees during 2005-2006. CMS considers these contracts too small to provide enough data to make reliable estimates of their coding patterns.

CMS proposes to calculate the 2009 MA coding adjustment as follows:

1. *Calculate the average annual difference between the increase in MA and FFS stayers' disease scores*. The average annual change in stayers' disease scores for a contract is calculated as the change in average disease score, averaged over as many cohorts of stayers that a contract has, e.g., CMS would calculate the annual average change in disease score for contracts that have been in existence since 2003 or earlier as the average of the change in disease score for the 2004-2005, 2005-2006, and the 2006-2007 stayer cohorts. We would then subtract the FFS annual average change in stayers' disease score to obtain the differential increase in stayers' disease scores. Changes in disease scores would be adjusted for age and survivor status.

2. *Calculate this average annual difference in the change in stayers' disease scores within that group of contracts that would fall above the threshold for applying the adjustment.* For example, we would calculate the annual average difference between MA and FFS stayers' disease score increase based only on MA data from those contracts where the difference between the change in stayers' disease scores and the change in FFS stayers' disease scores was two or more times the industry average. We would calculate the average disease score change for the set of contracts by weighting each contract's disease score change by the number of beneficiaries in each contract. We would then subtract the FFS disease score change from this weighted average. Based on the two years of data that were included in our analysis to date, the difference in the change in stayers' disease score for the contracts in this group and the FFS average is 0.050.

3. *Adjust the annual average difference in disease score change for the average percent of MA plan enrollees in the payment year who were enrolled in the same plan in the data collection year*. CMS currently estimates that this percentage of enrollees is approximately 75%, but will finalize the percentage after we add 2007 risk score data to our analysis. Based on our current estimate of 75% for the proportion of MA enrollees who are stayers, the adjustment for the contracts with the top 25% of MA enrollees with the largest difference between their change in disease score and the FFS change in disease score would be 0.0375. CMS (1) will update this calculation with 2007 data, (2) proposes to convert the adjustment amount into a percent change to risk scores in the Announcement, and (3) will consider whether to apply a straight average across the year-to-year differences, or whether to give more weight the disease score change differences in the most recent years. CMS requests comment on how we calculate the adjustment factor.

The average change in MA stayers' disease score, the change in MA stayers' disease scores for the top group of contracts, the FFS average change in disease score, the difference between MA and FFS, and the proportion of stayers we project to be enrolled in MA contracts in 2009, along with other calculations, will be updated in the Announcement.

Section F. Medicare as Secondary Payer (MSP) Adjustment Factor for Aged & Disabled Enrollees

MA capitation rates are calculated as if Medicare were always the primary payer; adjustments to the rates for situations in which Medicare is secondary are made as part of actual payment. The MSP adjuster applied to aged and disabled beneficiaries is calculated as the ratio of the actual Medicare spending for all MSP months for all MSP beneficiaries to the predicted Medicare spending for all MSP months for all MSP beneficiaries. Actual spending was calculated using the 2005 claims from the same analytic files used to recalibrate the CMS-HCC model. The predicted amount was calculated using the newly recalibrated CMS-HCC model. MSP status, which was determined using the working aged/working disabled status data in 2005, was used both for determining whom to exclude from the recalibration and for determining which beneficiaries to include in the MSP adjuster calculation.

CMS has recalculated the MSP adjuster for working aged and working disabled beneficiaries. The current adjuster of 0.215 will be revised to 0.174 in the 2009 payment year. There are two reasons for the change in the adjuster. First, CMS has refined the methodology used to calculate the adjuster. Previously, we prorated each beneficiary's MSP months using their total Medicare-paid costs during all months when beneficiary was enrolled. The new methodology includes costs only from those months in which beneficiaries have MSP status. Second, the average number of actual dollars calculated in the MSP months has decreased.

We are not proposing to change the formula for calculating the contract-level working aged/working disabled factor that is applied to each contract's total monthly payment for non-hospice/non-ESRD enrollees. We would simply change the value of the adjuster in that formula from 0.215 to 0.174.

Section G. ESRD Bidding and Payment

Pursuant to Section 1853(a)(1)(H) of the Act, CMS has the authority to determine whether to apply the competitive bidding methodology to ESRD enrollees, and must establish "separate rates of payment" with respect to ESRD beneficiaries.

G1. ESRD Bidding Policy

For 2009, CMS will continue the policy of excluding costs for ESRD enrollees in the plan A/B bid. The MA Bidding Instructions for CY 2009 will provide guidance on the option of adjusting A/B mandatory supplemental premiums to reflect the costs or savings for ESRD enrollees in the basic and supplemental benefits.

G2. Transition to New ESRD Payment

As announced in last year's Advance Notice, CMS continues the phase-in of the revised State capitation rates used to determine payments for enrollees in dialysis and transplant status. For payment year 2009, CMS will pay for ESRD dialysis and transplant enrollees using a blend of 50% of the old State ratebook (in use through 2007) and 50% of the revised State ratebook (implemented in 2008). The revised ESRD State ratebook reflects the dialysis-only trend. During the transition period, we will continue to trend forward the old and the revised State rates using the same dialysis-only growth trend. CMS is not rebasing the ESRD Dialysis State rates for 2009.

The full transition schedule is as follows. CMS payments for ESRD dialysis and transplant beneficiaries enrolled in MA plans will be:

- In 2008 (year 1): a blend of 75% old ratebook-based payments and 25% revised ratebook-based payments.
- In 2009 (year 2): a blend of 50% old ratebook-based payment and 50% revised ratebook-based payments.
- In 2010 (year 3): a blend of 25% old ratebook-based payments and 75% revised ratebook-based payments.
- In 2011: 100% of the revised ratebook.

In States where the revised dialysis rates are higher than the pre-2008 State rates, we will apply the revised ESRD State rates.

G3. ESRD Functioning Graft Payments

CMS pays for Functioning Graft enrollees with risk scores calculated using the aged-disabled CMS-HCC model coefficients, with the exception of the coefficient for HCC174 (Major Organ Transplant), which is not constrained, and the Graft factors, which are additive to the functioning graft risk scores. However, because CMS recalibrates the functioning graft coefficients along with the dialysis model, for 2009 CMS will continue to use the functioning graft coefficients published in the April 7, 2007 Advance Notice for 2008, when the ESRD dialysis model was last recalibrated. See Section C4 for a discussion of the normalization factors to be used with the functioning graft risk scores.

Section H. 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.

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

Section I. Continuation of Clinical Trial Policy

In 2009, we will continue the policy of paying on a fee-for-service basis for clinical trial items and services provided to MA plan members that are covered under the relevant National Coverage Determinations on clinical trials.

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

Per Section 1853(c)(1)(D)(iii) of the Act, CMS proposes to adjust to the extent appropriate the 2009 FFS rates to reflect CMS' "estimate, on a per capita basis, of the amount of additional payments that would have been made in the area involved under this title if individuals entitled to benefits under this title had not received services from facilities of the Department of Defense or the Department of Veterans Affairs."

The Office of the Actuary (OACT) proposes to compare the risk-adjusted Medicare reimbursements of dual-eligible individuals — those entitled to benefits under this title and entitled to benefits from the Department of Defense (e.g., DoD TRICARE for Life, DoD US Family Health Plan) or the Department of Veterans Affairs (VA) — with individuals entitled only under this title. In cases where groupings of dual-eligible individuals (who would possibly have services provided in VA or DoD facilities not reimbursed by Medicare) have risk-adjusted Medicare reimbursements significantly different from other Medicare-eligible individuals, we propose to adjust the MA FFS rates by excluding these individuals from the calculation. This

exclusion implicitly assumes that these individuals, if they had received all their services from Medicare-covered providers, would have the same risk-adjusted Medicare reimbursements as the remaining individuals.

MA FFS rates could be higher or lower under this adjustment. This is because the MA FFS rates are risk-adjusted rates. We note that under the current payment methodology we are missing two pieces of information on beneficiaries receiving health services through the VA or DoD:

1. The amounts Medicare would have reimbursed if these individuals had received their services from Medicare-covered providers rather than from VA/DoD providers.

2. Diagnostic information identified in VA/DoD-provided services but not identified in Medicare-covered services. Lack of diagnostic information could potentially understate individuals' risk scores.

Since the MA FFS rates are calculated using risk-adjusted reimbursements, there could be cases where the risk scores are understated to a greater extent than reimbursements leading to a reduction in the MA FFS rates in some counties.

In light of the foregoing, further information and analysis is required before making a final decision on the appropriateness of adjustments.

Section K. Operational Policies

K1. Reporting of Medicaid Status for Part C Payment

In CY 2009, CMS will complete the transition to using the MMA Medicare/Medicaid Dual Eligible monthly submission file (MMA State files) as the main source of Medicaid status for Part C plan payments. At the same time, CMS will end the use of the Third Party files as a source of Medicaid status. CMS anticipates that this change in Medicaid status source will improve – and increase – the identification of dual-eligible MA enrollees. As discussed in the 2008 Announcement (published April 2, 2007), CMS has found that the MMA State files identify approximately one million more dual eligibles than both the Third Party files and plan-reported data. (Please note that the changes discussed here only affect how we assign Medicaid status for Part C risk adjustment purposes, and that we are not changing how we identify deemed individuals for purposes of Part D payment.)

Plan Reporting. For any Medicaid period open on or after January 1, 2008, organizations may no longer submit batch "01" transactions to CMS. Instead, to request changes to Medicaid status, organizations must submit retroactive "01" transactions to IntegriGuard, as indicated in Table II-2.

Table II-2. Data sources for the assignment of Medicaid status

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

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

K2. Standard Set of ICD-9 Diagnosis Codes for Risk Adjustment

As discussed in the 2008 Announcement (released April 2, 2007), CMS is implementing the use of a standard set of valid codes to determine which plan-submitted diagnosis codes are acceptable for use in CMS's Risk Adjustment Processing System (RAPS). The goal is for RAPS to accept and store only those diagnoses codes that are valid. RAPS has historically accepted and stored old ICD-9 codes that had been superseded by more recent National Center for Health Statistics (NCHS) codes, i.e., invalid codes, without sending error messages to the plans. Having a standard set of valid codes for each year will make it more efficient for CMS and plans to manage risk adjustment processing, editing, and error reporting.

Starting with payment year 2009, RAPS will only accept valid ICD-9-CM codes for two fiscal years -- the fiscal year that begins prior to the payment year and the fiscal year that begins during the payment year -- for the CMS-HCC, ESRD, and RxHCC risk adjustment models. For example, for diagnoses codes to be used in 2009 final payment, i.e., for diagnoses from service dates between January 1, 2008 and December 31, 2008, RAPS will only accept codes that are valid for Fiscal Year 2008 and Fiscal Year 2009. (Please note that for the initial risk score run for payment year 2009, CMS will use valid diagnosis codes from FY 2007 and FY 2008 -- services dates between July 1, 2007 and June 30, 2008.)

Refer to Table II-3 for the implementation schedule of the new rules regarding the acceptance of diagnosis codes. Please note that Table II-3 of this Notice supersedes the table published in the April 2, 2007 Rate Announcement for 2008.

CMS is in the process of updating the "future diagnoses file" to eliminate invalid codes from that list. However, whether submitting diagnosis codes from the list of current model diagnoses or the list of future diagnoses, plans should resubmit an updated valid diagnosis code whenever they receive a RAPS error code specifying that a submitted diagnosis code is invalid. Both lists of current diagnosis codes and future diagnosis codes can be found in a zipped file on the CMS Web site at

http://www.cms.hhs.gov/MedicareAdvtgSpecRateStats/06_Risk_adjustment.asp#TopOfPage. Please refer to the HPMS memo released November 26, 2007 for a discussion of this policy and of the related RAPS error codes.

Table II-3. Acceptable diagnoses codes

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

Attachment III. Changes in the Payment Methodology for Medicare Part D for CY 2009

Section A. Benefit Design

A1. Medicare Part D Benefit Parameters: Annual Adjustments for Defined Standard Benefit in 2009

In accordance with section 1860D-2(b) of the Social Security Act (the Act), CMS must update the statutory parameters for the defined standard Part D prescription drug benefit each year. 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 the defined standard benefit 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 Part D drug expenses, and the defined standard Part D benefit continues to cover a constant share of Part D drug expenses from year to year. The Part D benefit parameters are updated using two indexing methods specified by statute: (i) the annual percentage increase in average expenditures for Part D drugs per eligible beneficiary or the "annual percentage increase", and (ii) the annual percentage increase in the Consumer Price Index (CPI) (all items, U.S. city average).

As required by statute, the first indexing method, the "annual percentage increase," is used to update the following Part D benefit parameters:

(i) the deductible, initial coverage limit, and out-of-pocket threshold for the defined standard benefit;
(ii) minimum copayments for costs above the annual out-of-pocket threshold;
(iii) maximum copayments below the out-of-pocket threshold for certain low-income full subsidy eligible enrollees;
(iv) the deductible for partial low-income subsidy (LIS) eligible enrollees; and
(v) maximum copayments above the out-of-pocket threshold for partial LIS eligible enrollees.

The benefit parameters listed above will be increased by 7.54% for 2009 as summarized by Table III-1 below. This increase reflects the 2008 annual percentage trend of 5.97% as well as a multiplicative update of 1.48% for prior year revisions. Please see Attachment V for additional information on the calculation of the annual percentage increase.

Per 42 CFR 423.886(b)(3), the cost threshold and cost limit for qualified retiree prescription drug plans are updated after 2006 in the same manner as the deductible and out-of-pocket threshold for the defined standard benefit. Thus, the "annual percentage increase" will be used to update these parameters as well. The cost threshold and cost limit for qualified retiree prescription drug plans will be increased by 7.54% from their 2008 values.

The statute requires CMS to use the second indexing method, the annual percentage increase in the CPI, 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 maximum copayments will be increased by 3.18% for 2009 as summarized in Table III-1 below.

This increase reflects the 2008 annual percentage trend in CPI of 2.60%, as well as a multiplicative update of 0.57% for prior year revisions. Please see Attachment V for additional information on the calculation of the annual percentage increase in the CPI.

Table III-1. Updated Part D Benefit Parameters for Defined Standard Benefit, Low-Income Subsidy, and Retiree Drug Subsidy

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

Part D Benefit Parameters	2008	2009
Standard Benefit Design Parameters		
Deductible	$275	$295
Initial Coverage Limit	$2,510	$2,700
Out-of-Pocket Threshold	$4,050	$4,350
Total Covered Part D Drug Spend at OOP Threshold (2)	$5,726.25	$6,153.75
Minimum Cost-sharing in Catastrophic Coverage Portion of Benefit		
Generic/Preferred Multi-Source Drug	$2.25	$2.40
Other	$5.60	$6.00
Part D Full Benefit Dual Eligible Parameters		
Copayments for Institutionalized Beneficiaries	$0.00	$0.00
Maximum Copayments for Non-Institutionalized Beneficiaries		
Up to or at 100% FPL		
Up to Out-of-Pocket Threshold (1)		
Generic/Preferred Multi-Source Drug (3)	$1.05	$1.10
Other (3)	$3.10	$3.20
Above Out-of-Pocket Threshold	$0.00	$0.00
Over 100% FPL		
Up to Out-of-Pocket Threshold		
Generic/Preferred Multi-Source Drug	$2.25	$2.40
Other	$5.60	$6.00
Above Out-of Pocket Threshold	$0.00	$0.00
Part D Non-Full Benefit Dual Eligible Full Subsidy Parameters		
Resources ≤ $6,290 (individuals) or ≤ $9,440 (couples) (4)		
Maximum Copayments up to Out-of-Pocket Threshold		
Generic/Preferred Multi-Source Drug	$2.25	$2.40
Other	$5.60	$6.00
Maximum Copayments above Out-of-Pocket Threshold	$0.00	$0.00
Resources bet $6,290-$10,490 (ind) or $9,440-$20,970 (couples) (4)		
Deductible (3)	$56.00	$60.00
Coinsurance up to Out-of-Pocket Threshold	15%	15%
Maximum Copayments above Out-of-Pocket Threshold		
Generic/Preferred Multi-Source Drug	$2.25	$2.40
Other	$5.60	$6.00
Part D Non-Full Benefit Dual Eligible Partial Subsidy Parameters		
Deductible (3)	$56.00	$60.00
Coinsurance up to Out-of-Pocket Threshold	15%	15%
Maximum Copayments above Out-of-Pocket Threshold		
Generic/Preferred Multi-Source Drug	$2.25	$2.40
Other	$5.60	$6.00
Retiree Drug Subsidy Amounts		
Cost Threshold	$275	$295
Cost Limit	$5,600	$6,000

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

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

(3) The increases to the LIS deductible, generic/preferred multi-source drugs and other drugs copayments are applied to the unrounded 2008 values of $55.91, $1.04, and $3.13 respectively.

(4) The actual amount of resources allowable will be updated for contract year 2009.

Office of the Actuary
Centers for Medicare and Medicaid Services
February 22, 2007

A2. Reporting Drug Costs When Contracting with a Pharmacy Benefit Manager (PBM)
In the 2008 Part D Payment Notification issued on April 2, 2007, we stated our intent to issue a Notice of Proposed Rulemaking proposing that the pass through amount (the amount received by the pharmacy or other dispensing provider) be the only acceptable price for determining beneficiary cost-sharing and reporting drug costs to CMS in 2009 and beyond. This Notice of Proposed Rulemaking was released in the Federal Register on May 25, 2007. CMS has reviewed the comments received and expects to issue the final rule in Spring 2008. This will allow sufficient time for Part D sponsors to prepare their 2009 Part D bids in accordance with the policies established in the final rule.

Section B. Bidding

B1. Calculation of the National Average Monthly Bid Amount
CMS will complete the transition to an enrollment-weighted average for the calculation of the national average monthly bid amount in 2009. Section 1860D-13(a)(4)(B) of the Act directs CMS to calculate the national average monthly bid amount each year as a weighted average of the standardized bid amounts for each prescription drug plan (PDP) and Medicare Advantage Prescription Drug Plan (MA-PD) described in section 1851(a)(2)(A)(i) of the Act starting in 2007. When calculating the national average monthly bid amount for contract year 2006, CMS assigned equal weighting to PDP sponsors, under section 1860D-13(a)(4)(B)(ii), because CMS did not have prior enrollment for these Part D plans. MA-PD plans were assigned a weight based on their prior MA enrollments and new MA-PD plans were assigned zero weight.

In 2007, CMS implemented the Medicare Part D demonstration entitled, "Medicare Demonstration to Limit Annual Changes in Part D Premiums Due to Beneficiary Choice of Low-Cost Plans," and began a transition from the 2006 method of calculating the national average monthly bid amount to the weighted average method based on actual plan enrollments. Under this demonstration, the national average monthly bid amounts for contract years 2007 and 2008 were calculated as a composite of (i) a weighted average calculated using the 2006 weighting methodology and (ii) a weighted average calculated based on actual plan enrollments. In 2007, 80% of the national average monthly bid amount was based on the 2006 averaging methodology and 20% was based on the enrollment-weighted average. In 2008, 40% of the national average monthly bid amount is based on the 2006 averaging methodology and 60% is based on the enrollment-weighted average. Please find the weighting methodologies for contract years 2006-2009 below.

Table III-2. Weighting Blends for the National Average Monthly Bid Amount

Contract Year	2006 Weighting	Enrollment Weighting
2006	100%	0%
2007	80%	20%
2008	40%	60%
2009	0%	100%

CMS will complete the transition to the weighted average method based on actual plan enrollments in 2009. Thus for contract year 2009, 100% of the national average monthly bid amount will be based on the enrollment-weighted average. The "Medicare Demonstration to

Limit Annual Changes in Part D Premiums Due to Beneficiary Choice of Low-Cost Plans" will not be extended for contract year 2009. The 2009 national average monthly bid amount and the reference month for the plan enrollment used to determine the enrollment-weighted average will be provided in future guidance after the June bid submission deadline.

B2. Calculation of the Low-Income Benchmark Premium Amount

The Medicare Prescription Drug Improvement, and Modernization Act of 2003 (MMA) directs CMS to use a weighted average to calculate the regional low-income benchmark premium amount used in the determination of the low-income premium subsidy amount. In determining the 2006 low-income benchmark premium amounts, PDPs were weighted equally, MA-PD plans were assigned a weight based on prior enrollment as of March 31, 2005, and new MA-PD plans were assigned a zero weight. In 2007, under the "Medicare Demonstration to Transition Enrollment of Low Income Subsidy Beneficiaries," CMS calculated the regional low-income benchmark premium amounts using the same weighting methodology applied in 2006, i.e., all PDP bids were weighted equally, and MA-PD bids received weights based on plan enrollments in the reference month (June 2006).

For contract year 2008, CMS implemented a transition to the statutorily required weighting such that the regional low-income benchmark premiums would experience a smaller decrease. CMS calculated the 2008 regional benchmarks using a composite of the 2006 weighting approach (simple average) and the statutory weighting formula (weighted average).

- The first component, the simple average, was the same as the 2006 weighting methodology for the regional low-income benchmark premium amount. The PDP organization premium amounts for basic prescription drug coverage in each region would be weighted equally and the MA-PD plan premiums, after the application of Part A/B rebates, would be weighted based upon prior enrollment.
- The second component was a weighted average of the premium amounts for each PDP and MA-PD with a weighting based on each plan's prior enrollment as a percentage of all beneficiaries enrolled in those plans.

In 2008, 50% of the regional low-income benchmark amount was based on the first component, the simple average, and 50% was based on the second component, the enrollment weighted average.

CMS proposes to calculate the 2009 regional benchmarks using a composite of the 2006 weighting approach (simple average) and the statutory weighting formula (weighted average) again. However, in 2009, 25% of the regional low-income benchmark amount will be based on the first component, the simple average, and 75% will be based on the second component, the enrollment weighted average. This proposal would continue the transition to the statutorily required weighting that was started in 2008, such that the regional low-income benchmark premiums would experience a smooth glide path to the statutory weighting approach.

Under the demonstration in 2007 and 2008, CMS also implemented a policy whereby Part D plans were required to charge full-subsidy eligible beneficiaries a monthly beneficiary premium equal to the low-income premium subsidy amount, if the plan's premium exceeded the low-

income premium subsidy amount by a certain "de minimis" amount. We do not propose to extend the "de minimis" component of this demonstration to 2009. On January 8, 2008, CMS published a proposed rule titled "Option for Prescription Drug Plans to Lower Their Premiums for Low-Income Subsidy Beneficiaries." It is our intent that the policy in the final version of this rule will replace the current "de minimis" policy.

B3. Coordination of Benefits (COB) User Fees

CMS is authorized to impose user fees on Part D sponsors for the transmittal of information necessary for benefit coordination between sponsors and other entities providing prescription drug coverage. CMS may review and update this user fee annually to reflect the costs associated with COB activities. For contract year 2008, the Part D COB user fee was $1.36 per enrollee per year. Upon review of the anticipated costs of COB activities in 2009, the Part D COB user fee will increase to $2.52 per enrollee per year for contract year 2009. This COB user fee will be collected at a rate of $0.28 per enrollee per month from January to September (for an annual rate of $0.21 per enrollee per month) for a total user fee of $2.52 per enrollee per year. Part D sponsors should account for this COB user fee when developing their 2009 bids.

B4. Budget Neutrality Offsets for Reinsurance Payment Demonstration Plans in 2009

The budget neutrality offsets applied to the capitated reinsurance payments for flexible capitated, fixed capitated, and Medicare Advantage rebate option plans will remain at $10.00 per member per year for contract year 2009. The Part D Reinsurance Payment Demonstration is a budget neutral alternative payment approach that provides an incentive for Part D sponsors to offer supplemental drug coverage to Medicare beneficiaries. Under this demonstration, Medicare pays participating Part D plans a capitated reinsurance payment that is actuarially equivalent to the federal reinsurance payments that they would otherwise receive when a beneficiary reaches the catastrophic phase of the Part D benefit ($4,050 in True Out-of-pocket costs for 2008).

This demonstration must be budget neutral as stated in the Instructions for Part D Payment Demonstration released on May 10, 2005 such that the expected Medicare costs under the demonstration are no more than the expected costs to the Medicare program in the absence of the demonstration. In order to ensure budget neutrality, the capitated reinsurance payments for all plans offered under the Part D Reinsurance Payment Demonstration were offset by $10.00 per member per year in 2008.

As stated in the Federal Register Notice published on February 25, 2005 (70 FR 9360), in order to ensure budget neutrality for this payment demonstration, CMS may increase these offsets each year in order to reflect an increase in the expected costs of the demonstration. The capitated reinsurance payments for 2009 must continue to be offset by $10.00 per member per year to ensure that the Part D Reinsurance Payment Demonstration remains budget neutral. When developing the 2009 bids for flexible capitated, fixed capitated, and Medicare Advantage rebate option plans, Part D sponsors should reflect this offset amount in the direct administrative expense line item of the Bid Pricing Tool (BPT).

Section C. Risk Adjustment

C1. Normalization Factor for the RxHCC Model

Please see Section C, item C3 in Attachment II, Changes in the Payment Methodology for Original Medicare Benefits for CY 2009.

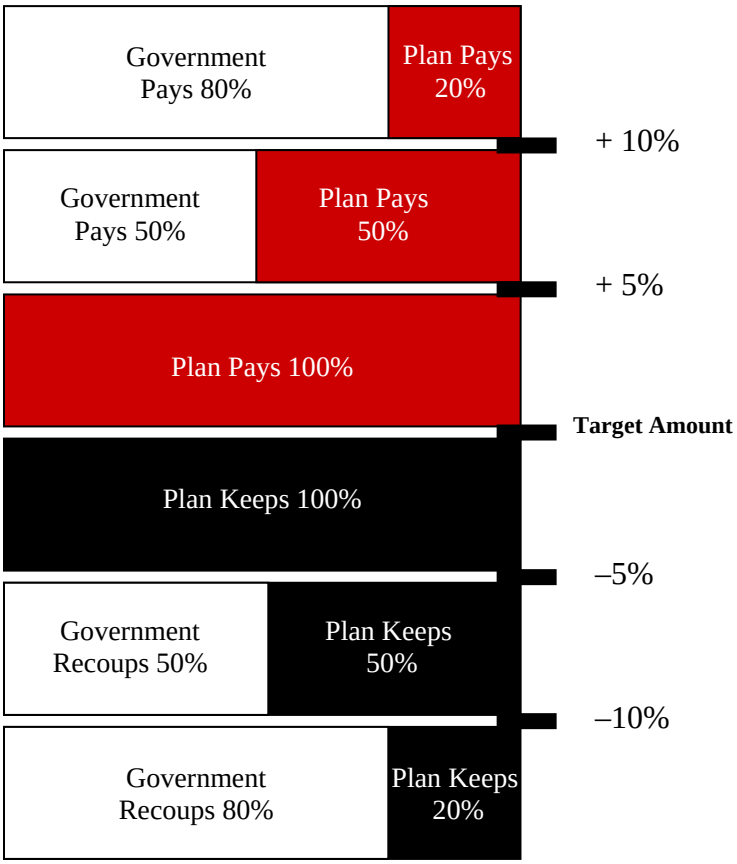
C2. Standard Set of ICD-9 Diagnosis Codes for Risk Adjustment

Please See Section K, item K2 in Attachment II, Changes in the Payment Methodology for Original Medicare Benefits for CY 2009.

Section D. Payment Reconciliation

Pursuant to section 1860D-15(e) of the 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 2008. The risk percentages for the first and second thresholds remain at 5% and 10% of the target amount respectively for 2009. The payment adjustments for the first and second corridors are 50% and 80% respectively. Please see Figure 1 below which illustrates the risk corridors for 2008-2011.

Figure 1. Part D Risk Corridors for 2008-2011



Attachment IV. Preliminary CMS-HCC Risk Adjustment Factors

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

Variable	Disease Group	Community Factors	Institutional Factors
Female			
0-34 Years		0.187	1.026
35-44 Years		0.206	0.884
45-54 Years		0.275	0.888
55-59 Years		0.333	0.943
60-64 Years		0.411	0.943
65-69 Years		0.299	0.971
70-74 Years		0.368	0.931
75-79 Years		0.457	0.835
80-84 Years		0.544	0.775
85-89 Years		0.637	0.704
90-94 Years		0.761	0.614
95 Years or Over		0.771	0.457
Male			
0-34 Years		0.120	1.030
35-44 Years		0.164	0.871
45-54 Years		0.217	0.871
55-59 Years		0.249	0.978
60-64 Years		0.389	1.015
65-69 Years		0.328	1.221
70-74 Years		0.413	1.154
75-79 Years		0.517	1.143
80-84 Years		0.597	1.087
85-89 Years		0.692	1.001
90-94 Years		0.834	0.932
95 Years or Over		0.980	0.743
Medicaid and Originally Disabled Interactions with Age and Sex			
Medicaid_Female_Aged		0.179	0.091
Medicaid_Female_Disabled		0.131	0.091
Medicaid_Male_Aged		0.166	0.091
Medicaid_Male_Disabled		0.077	0.091
Originally Disabled_Female		0.204	0.023
Originally Disabled_Male		0.168	0.023
Disease Coefficients	**Description Label**		
HCC1	HIV/AIDS	0.945	0.967
HCC2	Septicemia/Shock	0.759	0.764
HCC5	Opportunistic Infections	0.300	0.288
HCC7	Metastatic Cancer and Acute Leukemia	2.276	0.824
HCC8	Lung, Upper Digestive Tract, and Other Severe Cancers	1.053	0.470

Variable	Disease Group	Community Factors	Institutional Factors
HCC9	Lymphatic, Head and Neck, Brain, and Other Major Cancers	0.794	0.368
HCC10	Breast, Prostate, Colorectal and Other Cancers and Tumors	0.208	0.182
HCC15	Diabetes with Renal or Peripheral Circulatory Manifestation[1]	0.508	0.459
HCC16	Diabetes with Neurologic or Other Specified Manifestation[1]	0.408	0.459
HCC17	Diabetes with Acute Complications[1]	0.339	0.459
HCC18	Diabetes with Ophthalmologic or Unspecified Manifestation[1]	0.259	0.459
HCC19	Diabetes without Complication[1]	0.162	0.248
HCC21	Protein-Calorie Malnutrition	0.856	0.374
HCC25	End-Stage Liver Disease	0.978	0.654
HCC26	Cirrhosis of Liver	0.406	0.384
HCC27	Chronic Hepatitis	0.406	0.384
HCC31	Intestinal Obstruction/Perforation	0.311	0.345
HCC32	Pancreatic Disease	0.403	0.309
HCC33	Inflammatory Bowel Disease	0.241	0.205
HCC37	Bone/Joint/Muscle Infections/Necrosis	0.535	0.497
HCC38	Rheumatoid Arthritis and Inflammatory Connective Tissue Disease	0.346	0.215
HCC44	Severe Hematological Disorders	1.015	0.493
HCC45	Disorders of Immunity	0.912	0.427
HCC51	Drug/Alcohol Psychosis[3]	0.274	0.000
HCC52	Drug/Alcohol Dependence[3]	0.274	0.000
HCC54	Schizophrenia	0.524	0.351
HCC55	Major Depressive, Bipolar, and Paranoid Disorders	0.353	0.293
HCC67	Quadriplegia, Other Extensive Paralysis	1.011	0.434
HCC68	Paraplegia	0.993	0.434
HCC69	Spinal Cord Disorders/Injuries	0.558	0.225
HCC70	Muscular Dystrophy[3]	0.395	0.000
HCC71	Polyneuropathy	0.327	0.225
HCC72	Multiple Sclerosis	0.599	0.145
HCC73	Parkinson's and Huntington's Diseases	0.592	0.092
HCC74	Seizure Disorders and Convulsions	0.267	0.177
HCC75	Coma, Brain Compression/Anoxic Damage[3]	0.415	0.000
HCC77	Respirator Dependence/Tracheostomy Status	1.867	1.559
HCC78	Respiratory Arrest	1.082	1.235
HCC79	Cardio-Respiratory Failure and Shock	0.578	0.445
HCC80	Congestive Heart Failure	0.410	0.228
HCC81	Acute Myocardial Infarction	0.359	0.424
HCC82	Unstable Angina and Other Acute Ischemic Heart Disease	0.284	0.424
HCC83	Angina Pectoris/Old Myocardial Infarction	0.244	0.290
HCC92	Specified Heart Arrhythmias	0.293	0.207
HCC95	Cerebral Hemorrhage	0.324	0.179
HCC96	Ischemic or Unspecified Stroke	0.265	0.179
HCC100	Hemiplegia/Hemiparesis	0.437	0.039
HCC101	Cerebral Palsy and Other Paralytic Syndromes[3]	0.180	0.000
HCC104	Vascular Disease with Complications	0.610	0.482
HCC105	Vascular Disease	0.316	0.165

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

NOTES:

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

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

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

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

DM is diabetes mellitus (HCCs 15-19).
CHF is congestive heart failure (HCC 80).

COPD is chronic obstructive pulmonary disease (HCC 108).
CVD is cerebrovascular disease (HCCs 95, 96, 100, and 101).
CAD is coronary artery disease (HCCs 81-83).
RF is renal failure (HCC 131).

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

Exhibit IV-2. Preliminary Disease Hierarchies for the CMS-HCC Model

Hierarchical Condition Category (HCC)	If the Disease Group is Listed in This Column…	…Then Drop the Associated Disease Group(s) Listed in This Column
	Disease Group Label	
5	Opportunistic Infections	112
7	Metastatic Cancer and Acute Leukemia	8, 9, 10
8	Lung, Upper Digestive Tract, and Other Severe Cancers	9, 10
9	Lymphatic, Head and Neck, Brain and Other Major Cancers	10
15	Diabetes with Renal Manifestations or Peripheral Circulatory Manifestation	16, 17, 18, 19
16	Diabetes with Neurologic or Other Specified Manifestation	17, 18, 19
17	Diabetes with Acute Complications	18, 19
18	Diabetes with Ophthalmologic or Unspecified Manifestations	19
25	End-Stage Liver Disease	26, 27
26	Cirrhosis of Liver	27
51	Drug/Alcohol Psychosis	52
54	Schizophrenia	55
67	Quadriplegia/Other Extensive Paralysis	68, 69, 100, 101, 157
68	Paraplegia	69, 100, 101, 157
69	Spinal Cord Disorders/Injuries	157
77	Respirator Dependence/ Tracheostomy Status	78, 79
78	Respiratory Arrest	79
81	Acute Myocardial Infarction	82, 83
82	Unstable Angina and Other Acute Ischemic Heart Disease	83
95	Cerebral Hemorrhage	96
100	Hemiplegia/Hemiparesis	101
104	Vascular Disease with Complications	105, 149
107	Cystic Fibrosis	108
111	Aspiration and Specified Bacterial Pneumonias	112
130	Dialysis Status	131, 132
131	Renal Failure	132
148	Decubitus Ulcer of Skin	149
154	Severe Head Injury	75, 155
161	Traumatic Amputation	177

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

Exhibit IV-3. Preliminary 2009 CMS-HCC Model for New Enrollees

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

NOTES:

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

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

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

Attachment V. Medicare Part D Benefit Parameters for the Defined Standard Benefit: Annual Adjustments for 2009

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 2009, 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 $275 in 2008 and rounded to the nearest multiple of $5.

Initial Coverage Limit: From $2,510 in 2008 and rounded to the nearest multiple of $10.

Out-of-Pocket Threshold: From $4,050 in 2008 and rounded to the nearest multiple of $50.

Minimum Cost-Sharing in the Catastrophic Coverage Portion of the Benefit: From $2.25 per generic or preferred drug that is a multi-source drug, and $5.60 for all other drugs in 2008, 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 $2.25 per generic or preferred drug that is a multi-source drug, and $5.60 for all other drugs in 2008, and rounded to the nearest multiple of $0.05.

Deductible for Low Income (Partial) Subsidy Eligible Enrollees: From $56[1] in 2008 and rounded to the nearest $1.

Maximum Copayments above the Out-of-Pocket Threshold for Low Income (Partial) Subsidy Eligible Enrollees: From $2.25 per generic or preferred drug that is a multi-source drug, and $5.60 for all other drugs in 2008, 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 $1.05 per generic or preferred drug that is a multi-source drug, and $3.10 for all other drugs in 2008[2], 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. For the 2009 contract year benefit parameters, Part D program data is used to calculate the annual percentage trend as follows:

$$\frac{\textit{August}\ 2007 - \textit{July}\ 2008}{\textit{August}\ 2006 - \textit{July}\ 2007} = \frac{\$2{,}659.37}{\$2{,}509.48} = 1.0597$$

In the formula, the average per capita cost for August 2006 – July 2007 ($2,509.48) is calculated from actual Part D prescription drug event (PDE) data and the average per capita cost for August 2007 – July 2008 ($2,659.37) is calculated based on actual Part D PDE data incurred from August – December, 2007 and projected through July, 2008.

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[1] 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 2008 value of $55.91.

[2] Consistent with the statutory requirements of 1860D-14(a)(4)(A) of the Social Security Act, the copayments are increased from the unrounded 2008 values of $1.04 per generic or preferred drug that is a multi-source drug, and $3.13 for all other drugs.

The 2009 benefit parameters reflect the 2008 annual percentage trend as well as a revision to the prior estimates for the 2006 and 2007 annual percentage increases. Based on the updated NHE prescription drug per capita costs, the 2007 and 2008 increases are now estimated to be 6.45% and 6.59%, respectively. Accordingly, the 2009 benefit parameters reflect a multiplicative update of 1.47% (1.0645/1.0529 * 1.0659/1.0619 – 1) for prior year revisions. In summary, the 2008 parameters outlined in section I are updated by 7.54% for 2009 as summarized by Table V-1.

Table V-1. Annual Percentage Increase

Annual percentage trend for July 2008	5.97%
Prior year revisions	1.48%
Annual percentage increase for 2008	7.54%

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 2009, the September 2008 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 2008 CPI based on the projected amount included in the President's FY2009 Budget. The September 2007 value is from the Bureau of Labor Statistics. The annual percentage trend in CPI for contract year 2009 is calculated as follows:

$$\frac{\text{Projected September 2008 CPI}}{\text{Actual September 2007 CPI}} \textit{ or } \frac{213.9}{208.5} = 1.026$$

(Source: President's FY2009 Budget and Bureau of Labor Statistics, Department of Labor)

The 2009 benefit parameters reflect the 2008 annual percentage trend in the CPI, as well as a revision to the prior estimate for the 2007 annual percentage increase. The 2008 parameter update reflected an annual percentage trend in CPI of 2.17%. Based on the actual reported CPI for September 2007, the September 2007 CPI increase is now estimated to be 2.76%. Thus, the 2009 update reflects a multiplicative 0.57% (1.0276/1.0217 – 1) correction for prior year revisions. In summary, the cost sharing items outlined in section II are updated by 3.18% for 2009 as summarized by Table V-2.

Table V-2. Cumulative Annual Percentage Increase in CPI

Annual percentage trend for September 2008	2.60%
Prior year revisions	0.57%
Annual percentage increase for 2008	3.18%

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

IV. Part D Payment Demonstration Adjustment

The fixed capitated option of the Part D Payment Demonstration includes a catastrophic benefit that begins at the total drug expense corresponding to the out-of-pocket threshold in the Defined Standard Benefit. For 2009, this amount is increased from $5,726.50 in 2008 to $6,153.75. Specifically, this is the minimum amount of total covered Part D drug expenditures that will have occurred when the beneficiary reaches the out-of-pocket threshold of $4,350 in 2009 in the defined standard benefit. This expense level is determined arithmetically as a function of the 2009 out-of-pocket threshold (as opposed to being indexed directly).

V. 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 $265 and $5,350, respectively, for plans that end in 2007, and, as $275 and $5,600, respectively, for plans that end in 2008. For 2009, the cost threshold is increased to $295, and the cost limit is increased to $6,000.