DEPARTMENT OF HEALTH & HUMAN SERVICES
Centers for Medicare & Medicaid Services
Center for Beneficiary Choices
7500 Security Boulevard, Mail Stop S3-16-16
Baltimore, Maryland 21244-1850

CENTER FOR BENEFICIARY CHOICES

DATE: February 26, 2007

TO: All Medicare Advantage Organizations, Prescription Drug Plans, Cost Plans, PACE Organizations and Demonstrations

FROM: Abby L. Block
Director, Center for Beneficiary Choices

SUBJECT: **Target Amount Calculation for Flexible and Fixed Capitated Part D Payment Demonstration Plans and Induced Utilization for Enhanced Alternative Part D plans**

Overview

This letter discusses two formulas involved in Part D risk corridor calculations. These formulas previously published in payment guidance documents include errors that need to be corrected.

Flexible and Fixed Capitated Part D Payment Demonstration Target Amount

Section 1860-D15(e)(3)(B) of the Social Security Act defines the target amount for the purposes of risk corridors as the total payments based upon the standardized bid amount reduced by the total amount of administrative expenses assumed in the standardized bid. Pursuant to the plain language of the statute, risk is to be shared around drug costs only.

To reduce disincentives for providing enhanced alternative coverage, CMS pursued a payment demonstration under the authority of the Secretary of Health and Human Services granted by section 402 of the Social Security Amendments of 1967. We first expressed our intent to pursue this course of action in subpart G preamble of the Part D final rule published in the Federal Register on January 28, 2005.[1] In the final rule CMS noted that the demonstration would be budget neutral. The demonstration project did not include the authority to reduce the target amount for risk corridors by applying an administrative cost adjustment to payments that have no administrative cost component.

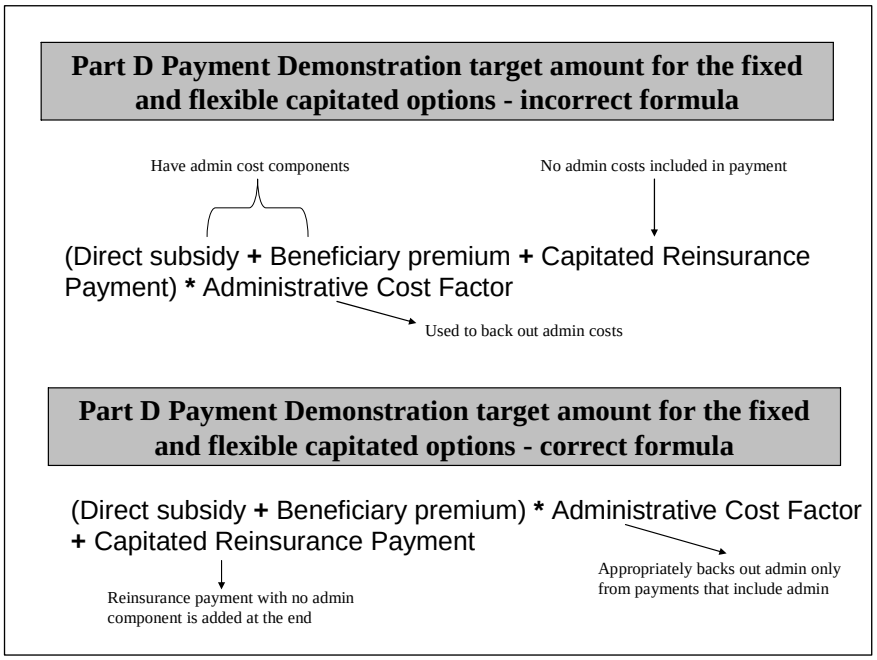
CMS announced the Part D Payment Demonstration in a Federal Register notice on February 25, 2005[2] and issued detailed policy guidance regarding the demonstration on May 10, 2005. Both documents clearly reiterated the budget neutrality requirements of the demonstration. Neither

[1] See page 4306 available online at:
http://a257.g.akamaitech.net/7/257/2422/01jan20051800/edocket.access.gpo.gov/2005/pdf/05-1321.pdf
[2] See page 9360 available online at:
http://a257.g.akamaitech.net/7/257/2422/01jan20051800/edocket.access.gpo.gov/2005/pdf/05-3621.pdf

document announced a change in policy with respect to the treatment of administrative costs in the calculation of the target amount under the demonstration. However, the May 2005 document did provide an erroneous formula, as an illustration, in the operational guidance section for Prescription Drug Event (PDE) submissions.[3] This incorrect formula appeared in two other operational guidance documents for PDE submissions.[4]

CMS believes that these illustrative formulas are in error because they would result in applying the administrative cost factor to the capitated reinsurance payment. This payment has no administrative component. Thus, implementation of this incorrect formula would result in artificially lowered target amounts and unauthorized higher costs to the Medicare program. The formula could be correct only if we made a policy change. However, we announced no such policy change in the narratives of either the February 25, 2005 Federal Register notice or the May 10, 2005 policy guidance. Moreover, since there would be no match on the non-demonstration side of the program, use of the erroneous formula would violate the budget neutrality requirements of the demonstration. See the figure below for a comparison between the correct and incorrect formulas.

Figure 1. Correct and incorrect target amount formulas for the Part D Payment Demonstration



[3] Page 21 of the "Instructions for the Part D Payment Demonstration" (May 10, 2005) available at http://www.cms.hhs.gov/DrugCoverageClaimsData/Downloads/partdpymntdemo.pdf

[4] Page 73 of the "Instructions: Requirements for Submitting PDE Data" (last updated 4/26/06) available at http://www.cms.hhs.gov/DrugCoverageClaimsData/01_PDEGuidance.asp#TopOfPage
Pages 35 and 41 of the "2006 PDE Training Participants Guide" (last updated October 2006) available at http://www.csscoperations.com/new/pdic/pdd-training/pdd-training.html

Implementing the Target Amount Correction for Flexible and Fixed Capitated Part D Payment Demonstration Plans

Effective with the release of this guidance, CMS is announcing the following corrected formula is to be used for calculating the target amount for both the fixed and flexible capitated Part D Payment Demonstration options:

TARGET = [(DS + BENE_PREM_ST_BID)*(1-adminstrative %)] + PROSP_REINS

Where:

- DS = Total direct subsidies
- BENE_PREM_ST_BID = Total basic beneficiary premiums related to the standardized bid, before this amount is reduced by any A/B rebate or paid by any other source such as the low-income premium subsidy
- PROSP_REINS = Capitated reinsurance payment

Risk Sharing Payments and Induced Utilization

This section deals with risk sharing calculations for all enhanced alternative plans irrespective of utilization of the demonstration authority. Allowable risk corridor costs are defined as actual plan paid costs for covered Part D drugs under the standard benefit. The costs exclude direct and indirect remuneration (DIR), enhanced alternative cost sharing amounts (if applicable), federal reinsurance payments, low-income cost sharing subsidy payments, and beneficiary cost sharing. If a plan offers enhanced alternative coverage (a.k.a. supplemental benefits), the insurance effect of supplemental benefits or induced utilization (IU) is excluded. Plans submitted their IU estimates in their bids.

CMS released the following erroneous formula[5]:

AARCC = (URCC/IU) – REINS_SUB – DDIR

Where:

- AARCC = adjusted allowable risk corridor costs
- URCC = unadjusted risk corridor costs
- IU = induced utilization ratio
- REINS_SUB = reinsurance subsidy
- DDIR = covered Part D DIR

Unadjusted Risk Corridor Costs = Covered D Plan Paid Amount (CPP) which is the Plan paid amount under the standard benefit submitted on the plan's PDE submissions. The CPP as submitted on the PDE is the net amount the Plan paid for standard benefits. No adjustments for reinsurance, DIR or induced utilization have been made. Adjusted allowable risk corridor costs are compared to the target amount. Target Amount equals the plan's total direct subsidy

[5] Page 58 of the "Instructions: Requirements for Submitting PDE Data" (last updated 4/26/06) available at http://www.cms.hhs.gov/DrugCoverageClaimsData/01_PDEGuidance.asp#TopOfPage
Pages 32, 41, 217 of the "2006 PDE Training Participants Guide" (last updated October 2006) available at http://www.csscoperations.com/new/pdic/pdd-training/pdd-training.html

payments plus the total beneficiary premiums related to standard bid amount less administrative expenses. The direct subsidy and beneficiary premium amounts are calculated from the standardized bid amount and are net of reinsurance and DIR. Under Enhanced Alternative coverage, the impact of supplemental coverage or IU is excluded from the standardized bid amount. Plans submitted their IU estimates in their bids on the basis of the standardized bid net of reinsurance and DIR.

Therefore, to reconcile the difference between the target amount as calculated based on the bid assumptions and the allowable risk corridor costs, the formula above is corrected to exclude the impact of induced utilization from the actual plan paid amounts for covered Part D drugs or CPP, as well as, the total reinsurance subsidy and DIR. The corrected formula is the following:

AARCC = (URCC – REINS_SUB – DDIR) / IU

Where:

- AARCC = adjusted allowable risk corridor costs
- URCC = unadjusted risk corridor costs
- IU = induced utilization ratio
- REINS_SUB = reinsurance subsidy
- DDIR = covered Part D DIR

Example

URCC	$135
Reins_Sub	$35
DDIR	$10
IU	1.025
Current AARCC formula = (135/1.025) - 35 - 10 =	$86.71
Corrected AARCC formula = (135 - 35 - 10) / 1.025 =	$87.80

The corrected adjusted allowable risk corridor cost formula results in a higher value that will be compared to the target amount for risk corridor purposes. In this example, if the current formula is used for risk corridor reconciliation, the plan may be disadvantaged by using an AARCC that is 1.3% lower than what should be used based on the assumptions included in the bid. The impact of this may include a plan making additional risk corridor payments or having reduced risk corridor receipts.

Questions concerning this guidance should be addressed to Mark Newsom at 410-786-3198 or by e-mail at mark.newsom@cms.hhs.gov