Wakely Consulting Group, Inc.
Summary of 2016 Medicare Advantage Advance Notice and Call Letter

CMS released the 2016 Advance Notice and Call Letter (the Notice) on February 20, 2015. This summary provides a high level description of the information included in the Notice. It contains the material Wakely views as important and should not be viewed as an all-inclusive summary. It has been written for those who are familiar with MA/PD programs and methods and condensed in order to keep it brief. The document in its entirety can be found at the following location:


Note that all information in the Notice is subject to change. CMS is requesting comments on the document. Comments can be emailed to AdvanceNotice2016@cms.hhs.gov by 6:00 PM Eastern Standard Time on Friday, March 6, 2015. The final 2016 Rate Announcement, which will include changes from and comments on the Notice, is scheduled to be released on Monday, April 6, 2015.
Table of Contents

Executive Summary.................................................................................................................. 4
Attachment I. Preliminary Estimate of the NPCMGP & FFS Growth Percentage ....................... 6
  Section A. MA Growth Percentage (also known as NPCMGP)............................................. 6
  Section B. FFS Growth Percentage......................................................................................... 6
Attachment II – Changes in the Part C Payment Methodology .................................................. 8
  Section A. MA Benchmark, Quality Bonus Payments and Rebates ..................................... 8
  Section B. Calculation of Fee for Service Rates.................................................................... 9
  Section C. IME Phase Out ....................................................................................................... 9
  Section D. ESRD State Rates................................................................................................. 9
  Section E. Clinical Trials ....................................................................................................... 9
  Section F. Location of Network Areas for PFFS Plans in Plan Year 2016............................... 9
  Section G. CMS-HCC Risk Adjustment Model for CY 2016.................................................. 10
  Section H. Coding pattern difference adjustment ............................................................... 10
  Section I. FFS Normalization Factors.................................................................................... 10
  Section J. Frailty Adjustments ............................................................................................... 11
  Section K. Medical Loss Ratio Credibility Adjustment .......................................................... 11
  Section L. ICD-10 Code Set.................................................................................................... 11
  Section M. Encounter Data as a Diagnosis Source for 2016 .............................................. 11
Attachment III – Changes in the Payment Methodology for Medicare Part D for CY2016 ........ 12
  Section A. Update of the RxHCC Model .......................................................................... 12
  Section B. Use of ICD-10 and Diagnosis Data Sources for 2016 Risk Score Calculations .... 12
  Section C. Encounter Data as a Diagnosis Source for 2016 ............................................. 12
  Section D. Payment Reconciliation ..................................................................................... 12
  Section E. Medicare Part D benefit Parameters: Defined Standard .................................... 13
  Section F. Reduced Coinsurance ....................................................................................... 13
  Section G. Dispensing Fees and Vaccine Admin................................................................. 13
Attachment IV – Medicare Part D Parameters for the Defined Standard Benefit Annual Adjustments for 2016 .......................................................... 14
  Section A. Annual Percentage Increase in Average Expenditures for Part D Drugs Per Eligible Beneficiary .............................................................. 14
  Section B. Annual Percentage Increase in Consumer Price Index, All Urban Consumers .... 14
  Section C. Calculation Methodology.................................................................................... 14
  Section D. Retiree Drug Subsidy Amounts......................................................................... 14
Section E. Annual Percentage Increase in Average Expenditures for Part D Drugs Per Eligible Beneficiary .................................................................................................................................................. 14
Attachment V – Preliminary RxHCC Risk Adjustment Factors .......................................................................................................................... 15
Attachment VI – 2016 Draft Call Letter .................................................................................................................................................. 16
Section I – Parts C and D ........................................................................................................................................................................ 16
Section II – Part C ..................................................................................................................................................................................... 22
Section III – Part D ..................................................................................................................................................................................... 27
Appendices ........................................................................................................................................................................................... 31
Appendix I: Contract Year 2016 Guidance for Prescription Drug Plan (PDP) Renewals and Non-Renewals .................................................................................................................................................. 31
Appendix II: Contract Year 2016 Guidance for Prescription Drug Plan (PDP) Renewals and Non-Renewals Table .................................................................................................................................................. 31
Appendix III: Beneficiary Access and Performance Problems (Revised Methodology) .................................................................................. 31
Appendix IV: Improvement Measures (Part C & D) .................................................................................................................................................. 31
Exhibit A - Wakely Estimated Impact of Growth Rates combined with Payment Reform .................................................................................. 32
Exhibit B – CY2016 Part D Defined Standard Benefit Parameters ........................................................................................................ 35
Exhibit C – MA MOOP and Cost Sharing Limit Tables .................................................................................................................................................. 37
Executive Summary

The majority of the changes discussed in the 2016 Advance Notice and Call Letter (the Notice) are the result of continuing implementation of the provisions of the Affordable Care Act (ACA), as well as continuing steps towards of CMS’ efforts to provide MA-PD enrollees with higher quality of care, more transparency and more information, and to continue moving towards quality based payments for both plan sponsors and providers. Many changes such as calculation/rebasng of the county Benchmarks, revisions to benefit parameters, and updates to risk score calculation components will affect nearly all Medicare Advantage and Prescription Drug Plans.

Following are the key changes and items proposed in the 2016 Notice:

PAYMENT METHODOLOGY

- MA growth rate percentage for CY2016 is 2.68%.
- Non-ESRD FFS growth rate percentage for CY2016 is 1.47%.
- CMS proposes to rebase the county benchmarks. As a result, benchmark changes will vary by county. The impact of the rebasing is NOT included in the Notice, and won’t be known until the Final Rate Announcement in April.
- As in 2015, in 2016 plans with less than 4 stars will not receive a quality bonus percentage. Plans with 4 or more stars will receive a 5% quality bonus percentage. New plan and low enrollment plans will receive a 3.5% bonus payment.
- Benchmarks will continue to be calculated on a blended basis for counties with a 6 year transition period. All other counties have benchmarks calculated completely based on the FFS benchmarks unless they are affected by the benchmark cap.

RISK SCORES

- The HCC model developed in 2014 has not been updated. However, the blending of the 2013 and 2014 HCC risk models is being eliminated. The 2016 risk scores are to be based 100% on the 2014 HCC model (2015 blend was 67% on 2013 HCC model and 33% on 2014 HCC model). This may have a significant impact on 2016 plan risk scores.
- 2016 MA coding adjustment factor was set at the statutory minimum of 5.41% (was 5.16% in 2015).
- 2016 FFS Normalization Factor for Part C is proposed as 0.992; for Part D is proposed as 0.939 (CMS is confirming the Part D factor). Due to the change in HCC blend, the 2016 FFS normalization factor will have a -0.5% impact on risk-adjusted benchmarks.
- The RxHCC model has been updated.
- 2016 risk scores will be calculated using a blend of RAPS and encounter data at weights of 90% and 10%, respectively.
- CMS will still allow home risk assessments to be used, but strongly encourage plans to implement minimum home visit standards.

BENEFIT CHANGES
- Cost sharing thresholds for MA and PD were updated. Some of the PD changes may significantly impact current plan designs.
- No change in MA MOOP amounts.
- There were several PBP changes.
- Part D parameters were updated, including changing the member coinsurance in the gap to 58% (was 65% in 2015).
- The Part D tier labeling has been changed; this may significantly impact current plan designs.

Wakely has developed an estimate of the overall impact of the changes discussed in the Notice on the 2016 benchmarks compared to the 2015 benchmarks. We have also performed a similar comparison of the resulting CMS revenue for 2016 versus 2015. Plans should be aware that the changes in the benchmarks can be considerably different (and typically are greater in magnitude) than the change in CMS revenue to the plan. Plans are paid 100% of their Part C basic bid (assuming they bid below the benchmark), which is unaffected by the benchmark for most plans, plus a percentage of the remaining difference of the excess of the benchmark above the bid. Therefore a reduction in the benchmark will impact plans differently based on the disparity of the plan’s bid compared to the benchmark (i.e. the “savings”) and the star-based percentage of the savings retained by the plan (i.e. Part C “rebate”).

Our nationwide average benchmark change estimate is 1.9% comparing 2015 Benchmarks to estimated 2016 Benchmarks. County specific values were aggregated using February 2015 CMS published MA enrollment and star ratings. Benchmarks are based on a 1.000 risk score.

Since CMS proposes to fully transition to 2014 HCC model, we estimate there will be a -4.1% impact on risk scores. After this and other risk score changes are taken into account, we estimate the risk-adjusted benchmark change to be -3.0%.

The risk-adjusted benchmark change refers to CMS MA payments only (excludes Part D payments and beneficiary premiums). Our estimated plan revenue change for 2016 is -1.4%. The revenue change includes assumptions regarding risk adjustment factors, Part C basic bid, diagnosis coding trend, and medical cost trend.

Details regarding our calculations and assumptions are provided in Exhibit A at the end of this summary.

The remainder of this summary includes many details discussed at length in the Notice.
Attachment I. Preliminary Estimate of the NPCMGP & FFS Growth Percentage

The Affordable Care Act (ACA) requires that the calculation of each MA county rate be based on a percentage of Medicare FFS spending in that county. It also provided a transition period of two to six years for moving each county to the new methodology. During the transition period, the county’s rate is based on a blend of the pre-ACA rate and the new ACA rate. For 2016, all counties on the two or four year transition schedule will be fully transitioned to the new methodology. Plans on the six year transition schedule will continue to have a blended rate. All counties will be fully transitioned by 2017.

The following table shows the transition schedule:

<table>
<thead>
<tr>
<th>Year</th>
<th>Two Year County Blend</th>
<th>Four Year County Blend</th>
<th>Six Year County Blend</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Pre-ACA</td>
<td>ACA</td>
<td>Pre-ACA</td>
</tr>
<tr>
<td>2012</td>
<td>1/2</td>
<td>1/2</td>
<td>3/4</td>
</tr>
<tr>
<td>2013</td>
<td>0</td>
<td>100%</td>
<td>1/2</td>
</tr>
<tr>
<td>2014</td>
<td>0</td>
<td>100%</td>
<td>1/4</td>
</tr>
<tr>
<td>2015</td>
<td>0</td>
<td>100%</td>
<td>0</td>
</tr>
<tr>
<td>2016</td>
<td>0</td>
<td>100%</td>
<td>0</td>
</tr>
<tr>
<td>2017</td>
<td>0</td>
<td>100%</td>
<td>0</td>
</tr>
</tbody>
</table>

Section A. MA Growth Percentage (also known as NPCMGP)

Preliminary estimates of the MA growth rates were announced as +2.68% (last year the rate was -4.07%).

Section B. FFS Growth Percentage

Fee-for-service growth rate estimated at 1.47% (last year rate was -1.65%).

Wakely estimates that the nationwide average change in blended standardized (non-risk adjusted) MA Benchmarks from 2015 to 2016 will be 1.9% and the nationwide average change in the blended risk adjusted benchmark will be -3.0%. Exhibit A at the end of this summary for additional detail.

As has been the case in past years, the change in benchmarks can vary significantly depending on geographic area and plan star rating. The table on the following page shows the top five and bottom five growth rates by State.
<table>
<thead>
<tr>
<th>Rank</th>
<th>State</th>
<th>Benchmark Change</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>RI</td>
<td>6.8%</td>
</tr>
<tr>
<td>2</td>
<td>TN</td>
<td>6.3%</td>
</tr>
<tr>
<td>3</td>
<td>OK</td>
<td>5.1%</td>
</tr>
<tr>
<td>4</td>
<td>OH</td>
<td>4.5%</td>
</tr>
<tr>
<td>5</td>
<td>UT</td>
<td>4.4%</td>
</tr>
<tr>
<td>48</td>
<td>NY</td>
<td>-0.2%</td>
</tr>
<tr>
<td>49</td>
<td>DC</td>
<td>-0.3%</td>
</tr>
<tr>
<td>50</td>
<td>AK</td>
<td>-0.3%</td>
</tr>
<tr>
<td>51</td>
<td>HI</td>
<td>-0.5%</td>
</tr>
<tr>
<td>52</td>
<td>PR</td>
<td>-2.7%</td>
</tr>
</tbody>
</table>
Attachment II – Changes in the Part C Payment Methodology

Section A. MA Benchmark, Quality Bonus Payments and Rebates
Payment reform for MA plans is being implemented another year as previously planned. Note the following:

- The pre-ACA rate is known as the “applicable amount”, while the new rate determined under the ACA is known as the “specified amount”.
- CMS plans to rebase county FFS rates for 2016 as part of the 2016 rate calculation.
- All benchmark rates are capped at the pre-ACA amount (this cap did not apply during 2012-2014 Quality Bonus Payment Demonstration for plans with a star rating of 3.0 or more).

For 2016, the “applicable amount” for each county will be the greater of 1) the county’s 2016 FFS rate or 2) the 2015 applicable amount increased by the CY 2016 NPCMGP growth rate.

The “specified amount” for each county in 2015 will be based on a percentage of the 2015 FFS rate. The formula is as follows:

\[
\text{Specified amount} = (2016 \text{ FFS rate} - \text{IME phase out}) \times (\text{aplicable \% + quality bonus \%})
\]

**Applicable Percentage**
For 2016, county applicable percentages will be updated based on the current quartile ranking of the county’s FFS amount. If there is a change in the applicable percentage for a county, the 2016 applicable percentage will be the average of last year’s percentage and the new percentage.

The following table shows the applicable percentage by county quartile ranking:

<table>
<thead>
<tr>
<th>Quartile</th>
<th>Applicable Percentage</th>
</tr>
</thead>
<tbody>
<tr>
<td>4th (highest)</td>
<td>9.5%</td>
</tr>
<tr>
<td>3rd</td>
<td>10.0%</td>
</tr>
<tr>
<td>2nd</td>
<td>107.5%</td>
</tr>
<tr>
<td>1st (lowest)</td>
<td>111.5%</td>
</tr>
</tbody>
</table>

**Qualify Bonus Payment Percentage**
Plans with a 4 star rating or higher will receive a 5% quality bonus payment percentage. Plans with less than a 4 star rating will not receive a quality bonus payment.

A new plan under a new parent organization or a plan designated as low enrollment will be treated as a “qualifying” plan and will receive a 3.5% quality bonus payment.

**Rebate Percentages**
The following table shows the rebate percentages by star rating:
A new plan under a new parent organization or a plan designated as low enrollment will be treated as a “qualifying” plan and will be treated as a 3.5 star plan and receive 65% rebate percentage.

**Section B. Calculation of Fee for Service Rates**

The FFS rate for each county is the product of 1) the National FFS rate (USPCC) and 2) a county-level geographic index, called the average geographic adjustment (AGA).

For 2016, CMS is proposing to calculate AGAs using an approach similar to 2015:
- Use 5 years of data (2009 to 2013 for 2016)
- Re-price the historical IP, OP, SNF, and HH claims from 2009 – 2013 to reflect the most current (i.e., FY 2015) wage indices
- Re-tabulate physician claims with the most current (i.e., CY 2015) Geographic Practice Cost Index.
- Additional changes to AGA calculation:
  - Uncompensated care payments: Re-price 2009-2013 DSH payments to reflect revised uncompensated care payments in effect for 2016
  - Competitive bidding for DME: Propose to re-price DME claims from 2009 to 2013 to reflect the most current DME prices in each of the Round 1 and Round 2 bidding areas

**Section C. IME Phase Out**

IME phase out continues, subject to maximum reduction of 4.2%.

**Section D. ESRD State Rates**

The 2015 ESRD rates by state are determined by multiplying the 2016 FFS ESRD USPCC by the state AGA.
- Geographic adjustments are calculated based on ESRD cost relativities by state.
- 2016 ESRD rates are adjusted by GME and IME.

**Section E. Clinical Trials**

CMS will continue paying on a FFS basis for qualified clinical trial items.

**Section F. Location of Network Areas for PFFS Plans in Plan Year 2016**

The following applies to MA organizations offering certain non-EGWP MA PFFS plans in specified areas:

When 2 or more network plans in a county, PFFS plans must also have networks (same as last year). Will use January 1, 2015 enrollment data to identify the location of network areas for plan year 2017. The list of specified areas can be found here:

[http://www.cms.gov/Medicare/Health-Plans/PrivateFeeforServicePlans/NetworkRequirements.html](http://www.cms.gov/Medicare/Health-Plans/PrivateFeeforServicePlans/NetworkRequirements.html)
Section G. CMS-HCC Risk Adjustment Model for CY 2016
CMS proposes to fully implement the 2014 HCC model for 2016 risk score calculations. Risk score calculations in 2015 are based on a 67%/33% blend of 2013/2014 HCC models. CMS estimates that the changing blend will result in about 1.7% lower revenue. For specific plans, the impact could be higher or lower.

Section H. Coding pattern difference adjustment
The coding pattern difference adjustment for 2015 is 5.41%, which is the minimum factor allowed by the ACA.

CMS believes the health status of MA enrollees is likely better than FFS beneficiaries of similar age, gender, Medicaid, and institutional status. In light of this belief, CMS is considering a new approach for calculating the coding pattern difference adjustment in 2017. The new approach would calculate the difference in coding by calibrating the adjustment such that aggregate MA payments would be no greater than if payments were calculated using the pre-2000 age, gender, Medicaid status, and institutional status factors.

In addition to the coding pattern adjustment factor, CMS also notes that results from pilot RADV audits indicate that “some diagnoses submitted to MA organizations are not supported by medical record documentation”. It further notes that RADV audits are CMS’s primary corrective action to recoup Part C improper payments.

CMS is requesting comments and feedback on these items.

Section I. FFS Normalization Factors

<table>
<thead>
<tr>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>2014</td>
<td>2012</td>
<td>0.992</td>
<td>100%</td>
<td>0.978</td>
<td>33%</td>
<td></td>
</tr>
<tr>
<td>2013</td>
<td>2011</td>
<td></td>
<td>0%</td>
<td>0.992</td>
<td>67%</td>
<td></td>
</tr>
<tr>
<td>Blend</td>
<td></td>
<td>0.992</td>
<td>0.987</td>
<td></td>
<td>-0.5%</td>
<td></td>
</tr>
</tbody>
</table>

- Rx normalization factor for 2016 is 0.939 (vs. 0.961 in 2014). Note that a questioner on a CMS call asked whether this factor was transposed. CMS responded that it would look into the issue.
- PACE normalization factor for 2016 is 1.042
- ESRD normalization factor for 2016 is 0.990
- ESRD functioning graft normalization factor for 2016 is 1.042

In general, lower normalization factors will lead to 1.0 bids being lower vs. 2015, all else equal.
Section J. Frailty Adjustments
Frailty factors for PACE organizations will not change from 2014.

Section K. Medical Loss Ratio Credibility Adjustment
CMS will use the following credibility adjustments for MLR purposes in CY2016:

<table>
<thead>
<tr>
<th>MA-PD Plans</th>
<th>PDP Plans</th>
</tr>
</thead>
<tbody>
<tr>
<td>Member Months</td>
<td>Credibility Adjustment</td>
</tr>
<tr>
<td>&lt;2,400</td>
<td>Non-credible</td>
</tr>
<tr>
<td>2,400</td>
<td>8.4%</td>
</tr>
<tr>
<td>6,000</td>
<td>5.3%</td>
</tr>
<tr>
<td>12,000</td>
<td>3.7%</td>
</tr>
<tr>
<td>24,000</td>
<td>2.6%</td>
</tr>
<tr>
<td>60,000</td>
<td>1.7%</td>
</tr>
<tr>
<td>120,000</td>
<td>1.2%</td>
</tr>
<tr>
<td>180,000</td>
<td>1.0%</td>
</tr>
<tr>
<td>&gt;180,000</td>
<td>Fully credible</td>
</tr>
</tbody>
</table>

There was no change to the MLR credibility adjustments from previous publications.

Section L. ICD-10 Code Set
CMS proposes to collect both ICD-9 and ICD-10 diagnoses in 2015 to use for calculating 2016 risk scores. ICD-9 codes will be used through September 30, 2015, and ICD-10 will be used from October 1, 2015 through December 31, 2015.

Section M. Encounter Data as a Diagnosis Source for 2016
CMS proposes to calculate 2016 risk scores using a blend of RAPS/FFS data and encounter data. The blends are as follows:

<table>
<thead>
<tr>
<th>Data Source</th>
<th>CY2016 Blend</th>
</tr>
</thead>
<tbody>
<tr>
<td>RAPS and FFS Data</td>
<td>90%</td>
</tr>
<tr>
<td>Encounter Data System</td>
<td>10%</td>
</tr>
</tbody>
</table>

CMS noted on the February 24 call that EDS data would be made available to plans in the future to allow plans to analyze the impact of the blended risk score calculation.
Attachment III – Changes in the Payment Methodology for Medicare Part D for CY2016

Section A. Update of the RxHCC Model
Following are the changes to the RxHCC model for 2016:

- Re-Calibration for 2016 Benefit Structure: Updated to reflect gap plan liability for non-LIS beneficiaries will be 42% for generics and 5% for brand scripts – an increase in plan liability for non-LIS beneficiaries relative to LIS beneficiaries.
- Model data updated to include 2012 diagnoses and 2013 PDE data (current model uses 2010 diagnoses and 2011 PDE data).
- 2016 model has 76 RxHCCs compared to 78 for the 2014 model, which is the net impact of:
  - Two new RxHCCs: “Secondary Cancers of Bone, Lung, Brain, and Other Specified Sites; Liver Cancer” & “Chronic Viral Hepatitis C”
  - Four RxHCCs were removed.
- The 2016 RxHCCs are re-numbered; to avoid this in the future, CMS left gaps in the numbering between groups.
- MA-PD data are included in the model for calibration: The 2014 model only utilized FFS diagnosis and PDP PDE data for calibration. The 2015 and 2016 models include MA-PD RAPS diagnosis data and PDE data, which represents nearly 40% of all Part D enrollment.
- CMS made an actuarial adjustment to the new “Chronic Viral Hepatitis C” RxHCC to account for the substantial costs associated with the new Hepatitis C treatments not captured in the base data used to calibrate the model. The adjustment increased the Chronic Viral Hepatitis C RxHCC. CMS considers this adjustment to be temporary and will reconsider its use in the future.

Quantification of the changes was not provided.

Section B. Use of ICD-10 and Diagnosis Data Sources for 2016 Risk Score Calculations
The ICD-10 diagnoses coding system is scheduled to become effective 10/1/2015. As in MA, both ICD-9 codes (1/1/2015– 9/30/2015 dates of service) and ICD-10 codes (10/1/2015-12/31/2015) will be used in calculating 2016 risk scores.

Section C. Encounter Data as a Diagnosis Source for 2016
CMS proposes calculation of the 2016 risk score from two data sources:

1. Diagnoses with CY2015 dates of service from RAPS and FFS data
2. Diagnoses with CY2015 dates of service from EDS and FFS data

The final risk score will be a blend of the above two risk scores with 90% weight on the first and 10% on the second. CMS noted on the February 24 call that EDS data would be made available to plans in the future to allow plans to analyze the impact of the blended risk score calculation.

For PACE, the CY2015 method will continue for CY2016.

Section D. Payment Reconciliation
There are no changes to the Part D risk corridor calculations in 2016.
Section E. Medicare Part D benefit Parameters: Defined Standard

Part D Defined Standard benefit changes:
- $360 deductible ($320 in 2015)
- $3,310 ICL ($2,960 in 2015)
- $4,850 TrOOP ($4,700 in 2015)
- $1.20/$3.60 copays for full subsidy full benefit duals (unchanged)

See Exhibit B at the end of this summary for detailed table of all Part D defined standard parameters.

Section F. Reduced Coinsurance

Phase-in of reduced non-LIS cost sharing in the gap continues, with ultimate levels (75% for brand drugs and 25% for generic drugs) to be accomplished by 2020. The non-LIS gap cost sharing for 2016 is as follows:
- Non-LIS 58% coinsurance for generics in gap (was 65% in 2015)
- Non-LIS 95% coinsurance for brands in gap (unchanged). Note that member liability is approximately 45% after 50% manufacturer discount.

Reductions in non-LIS coinsurance will result in lower TrOOP, which is to be reflected in the bids.

Section G. Dispensing Fees and Vaccine Admin

Consistent with the gap cost sharing reductions discussed above, member liability is 58%/45% (generic/brand) and plan liability is 42%/55% (generic/brand) for dispensing fees and vaccine administration fees in the gap.
Attachment IV – Medicare Part D Parameters for the Defined Standard Benefit
Annual Adjustments for 2016

Attachment IV contains detailed calculations of the annual adjustments to the Part D Defined Standard
benefit parameters. Two annual percentage adjustments are calculated to develop the 2016 benefit
parameters: the annual percentage increase and the annual Consumer Price Index (CPI) increase. These
adjustments are described below. The annual percentage increase is applied to all Part D parameters
except for the copayments for the full benefit dual eligible enrollees with up to or at 100% FPL, which
increases by CPI.

Section A. Annual Percentage Increase in Average Expenditures for Part D Drugs Per Eligible
Beneficiary
The annual percentage increase is defined as the annual percentage increase in the average per capita
expenditures for Part D for the 12-month period ending in July of the previous year.

Section B. Annual Percentage Increase in Consumer Price Index, All Urban Consumers
The annual Consumer Price Index (CPI) increase is defined as the annual percentage increase in the CPI,
All Urban Consumers (all, items, U.S. city average) as of September of the previous year.

Section C. Calculation Methodology
The annual percentage increase uses prescription drug event (PDE) data to calculate the per capita Part
D costs from August 2014 to July 2015 divided by the per capita Part D costs from August 2013 to July
2014. Since PDE data is not yet available for 2015, the per capita costs for this time period are
estimated using August to December 2014 PDE data. This calculation results in an estimated 6.37%
annual increase in per capita costs. This increase is further adjusted based on revisions to prior years’
estimates. The cumulative adjustment for prior year revisions is 5.07%, primarily driven by an
adjustment to last year’s annual percentage increase. This results in a total 2016 annual percentage
increase of 11.76%.

The CPI increase is based on the projected September 2015 CPI divided by the actual September 2014
CPI, which results in an estimated increase of 1.45%. The CPI is adjusted for the revision in the prior
year estimate, which is 0.17%. In total this produces a 2016 CPI increase of 1.62%.

Section D. Retiree Drug Subsidy Amounts
The Part D parameters, including the retiree drug subsidy amount, are each multiplied by the
appropriate increase (CPI or annual percentage increase). For 2016, the retiree subsidy cost threshold is
$360 (was $320 in 2015) and the cost limit is $7,400 (was $6,600 in 2015).

Section E. Annual Percentage Increase in Average Expenditures for Part D Drugs Per Eligible
Beneficiary
The 2016 total covered Part D spending at out-of-pocket threshold for applicable beneficiaries is
calculated to be $7,515.22. This amount is calculated as the ICL plus 100 percent beneficiary cost sharing
divided by the weighted gap coinsurance factor. Further detail on these calculations and inputs is
provided in the Notice.
Attachment V – Preliminary RxHCC Risk Adjustment Factors

The following summarizes the changes in the risk adjustment factors, comparing the proposed 2016 model to the 2014 model, which was used in 2015:

- Rx-HCCs adjustment factors are generally higher although there are significant variations by HCC and by population.
- Age factors are generally lower for continuing enrollees except for institutional and “community, non-low income, age < 65”, which are generally higher.
- For new enrollees, the ESRD and disabled factors are generally higher, including for institutionalized enrollees. The exception is for low income disabled-only new enrollees, whose factors are generally lower.
- The new enrollee factors are generally lower for non-ESRD, non-disabled enrollees 65 and older although they are higher for some non-low income enrollees around age 70 and higher. The factors are higher for non-ESRD, non-disabled enrollees under age 65.

See pages 48 to 55 of the Notice for a detailed list of the 2016 risk adjustment factors.
Attachment VI – 2016 Draft Call Letter

Section I – Parts C and D

Annual Calendar: Key Upcoming Dates
The following bullet points contain major/key items for 2016 bid submission. The full detailed list can be found on pages 64-69 of the Advance Notice.

- Early April 2015: CY 2016 OOPC Model and OOPC estimates for each plan made available.
- April 6, 2015: 2016 Final Announcement of MA Capitation Rates and MA/Part D Payment Policies released.
- April 10, 2015: Release of the 2016 PBP online training module.
- April 10, 2015: Release of the 2016 Plan Creation Module, PBP, and BPT software in HPMS.
- April 15, 2015: Deadline for MAOs to submit requests for full contract consolidations for CY 2016.
- Late April 2015: TBC data for CY 2016 Bid Preparation Release.
- May 1, 2015: MA/MA-PD/PDP plans to notify CMS of intention to non-renew county(ies) for individuals, but continue the county(ies) for “800 series” EGWP members.
- May 8, 2015: Release of the 2016 Bid Upload Functionality in HPMS.
- May 8, 2015: Release of 2016 Actuarial Certification Module in HPMS.
- May 8, 2015: Release of 2016 Formulary Submission Module in HPMS.
- June 1, 2015: Deadline for submission of CY 2016 bids for all MA/MAPD/PDP plans. Deadline for submission of a CY 2016 contract non-renewal, service area reduction notice to CMS from MA/MAPD/PDP plans.
- Late June 2015: Release of the CY 2016 Summary of Benefits (SB) hard copy change request module in HPMS.
- Late July/Early August 2015: CMS releases the 2016 Part D national average monthly bid amount, the Medicare Part D base beneficiary premium, the Part D regional low-income premium subsidy amounts, the MA regional PPO benchmarks, and the de minimis amount.
- Late July/Early August 2015: Rebate reallocation period begins after release of the above bid amounts.
- Late August/Early September 2015: Plan preview period of Star Ratings in HPMS.
- October 1, 2015: Tentative date for 2016 plan and drug benefit data to be displayed on Medicare Plan Finder on Medicare.gov.
- Star Ratings go live on medicare.gov.
- December 7, 2015: End of AEP.

Incomplete and Inaccurate Bid Submissions
The following components—where applicable—are required to constitute a complete bid submission:
- PBP and BPT
- Service Area Verification
• Plan Crosswalk
• Formulary Submission (for plans offering PD coverage with a formulary)
• Formulary Crosswalk (for plans offering PD coverage with a formulary)
• Substantiation (supporting docs)

If any of the above components are not submitted by the deadline, the bid submission will be considered incomplete and not accepted.

Organizations that submit inaccurate bids that fail to meet Part C and D requirements and established thresholds will receive a compliance notice in the form of a letter or a corrective action plan.

Plan Corrections
The plan correction window will be open from early September to late September 2015. The only changes to the PBP that will be allowed during the plan correction period are those that modify the PBP data to align with the BPT. No changes to the BPT are permitted during this time.

In advance of the bid submission deadline, CMS will provide organizations and sponsors the guidance and tools necessary for a complete and accurate bid submission. These tools include a Medicare Plan Finder (MPF) summary table that will be released in HPMS in May. Organizations and sponsors submitting plan corrections will receive a compliance action and will be suppressed in MPF until the first update in November.

Formulary Submissions
The formulary submission window will open on May 8, 2015 and close at midnight PST on June 1, 2015. CMS must be in receipt of a successfully submitted and validated formulary by the deadline in order for the formulary to be considered for review.

CMS will release the first CY 2016 Formulary Reference File (FRF) in March 2015. The March FRF release will be used in production of the Out-Of-Pocket Cost (OOPC) model tool, scheduled for release in April 2015. The 2016 May release of the FRF will be in late May 2015, but any drugs added to the final FRF version will not be included in the 2016 OOPC model due to the timing of the release.

CMS is enhancing the Quantity Limit (QL) submission process for 2016. The HPMS formulary file field descriptors and allowable values will be changed for CY 2016. The Quantity_Limit_YN field will be changed to a Quantity_Limit_Type field (0 = No QL, 1 = Daily QL, 2 = QL over time). Additional submission instructions will be provided with the CY 2016 formulary submission training and technical manual.

For mid-year formulary changes, both maintenance (e.g. generic substitution) and non- maintenance changes (e.g. therapeutic substitution) must be submitted to and approved by CMS. For CY2016, CMS will maintain the CY 2015 July 31 deadline for both maintenance and non- maintenance changes for CY 2016. With respect to non-maintenance changes, CMS proposes eliminating the current prohibition on sponsors providing advance notice to required parties until CMS explicitly approves the change. Substantial changes to the formulary that was initially approved will not be permitted.
Revisions to Good Cause Process
On February 12, 2015, CMS published final regulations providing CMS with the authority to designate an entity to act on behalf of CMS to effectuate reinstatements when good cause criteria are met. These regulations allow CMS to assign another entity (i.e. MAO, PD sponsor) the authority to carry out portions or all of the good cause process.

CMS intends to assign the responsibility to conduct good cause reviews to MAOs and PD plan sponsors for CY 2016 and will expect that they perform the work from start to finish for individuals disenrolled effective December 31, 2015 and later. CMS will retain the authority to review both favorable and unfavorable decisions to ensure results are fair.

Enrollment Eligibility for Individuals Not Lawfully Present in the United States
CMS published final regulations on February 12, 2015 establishing US Citizenship or lawful presence as a requirement to be eligible to enroll in an MA/MAPD/PDP plan. Enrollment requests for ineligible individuals will be denied, and CMS will involuntarily disenroll any current plan members for which CMS receives data of their unlawful presence status.

Making the Exceptions and Appeals Processes More Accessible for Beneficiaries
MAOs and PD sponsors continue to have unacceptably high rates of non-compliance for MAO determination, appeal, and grievance (ODAG) and Part D coverage determination, appeal, and grievance (CDAG).

Denial Notices: MAO and PD sponsors must make certain that enrollees and providers receive accurate, clear, and detailed information related to the specific reasons for denial (i.e. not a covered benefit). Additionally, the applicable Medicare coverage rule or plan policy (i.e. EOC provision) must be described in the denial notice.

Requesting Clinical Documentation: If an MAO or PD sponsor needs clinical information in order to make a substantive and thorough clinical decision on a coverage request, the MAO or PD sponsor should request necessary documentation from the provider and document the outreach efforts.

Future Improvements: To improve PD sponsor compliance with the above requirements, CMS will be revising the Part D denial notice to include:
- A new section of the standard notice that plans will populate with detailed clinical information about the basis for the denial, relevant coverage policy, and the information needed to cover the item.
- Plans will be required to, wherever possible, include extracted language from the relevant sections of the CMS-approved formulary in this new section of the denial notice.

Improved Information at Point of Sale (POS): When enrollees’ Rxs cannot be filled under the Part D benefit and the issue cannot be resolved at POS, the current pharmacy notice does not include any required personal information (pharmacies can include the enrollee’s name and the drug or Rx number, but these fields are not required). CMS requests feedback how best to approach any potential changes.

Expanded Data Collection for Part D Appeals: The data currently available to CMS (aggregate quarterly data submitted by plans via annual reporting) do not provide sufficient information to allow CMS to determine whether plans are providing appropriate access to Part D drugs through their coverage
determination process. CMS proposes exploring the development of an appeals tracking system to receive regular data feeds for all coverage requests received and processed by plans in order to obtain a full data-stream of information from beginning (coverage determination) to end (Independent Review Entity).

**Contracting Organizations with Rating of Less Than Three Stars in Three Consecutive Years—Timeline for Application of Termination Authority**
CMS may, under regulatory authority, terminate the contracts of organizations that, upon release of the 2016 star ratings in October 2015, have failed in three consecutive years to achieve at least three stars on their Part C or Part D performance. After the 2016 ratings are released in late 2015, these contracts will receive non-renewal notices from CMS in February 2016 with an effective date of December 31, 2016.

**Enhancements to the 2016 Star Ratings and Beyond**
Unless noted below, CMS does not anticipate methodology changing from the 2015 Star Ratings. For reference, a list of measures and methodology included in the 2015 Star Ratings is described in the Technical Notes: [http://go.cms.gov/partcanddstarratings](http://go.cms.gov/partcanddstarratings)

Following are the proposed enhancements for 2016:
- **Pre-determined Thresholds**—The use of pre-determined 4-star thresholds violates CMS’ principle of assigning stars that maximize the difference between star categories. CMS will proceed as originally planned and as announced in prior Call Letters and eliminate all pre-determined 4-star thresholds for the 2016 Star Ratings.
- **New 2016 Measure**—Medication Therapy Management (MTM) Program Completion Rate for Comprehensive Medication Reviews (Part D)—This measure is used to calculate the percentage of beneficiaries who met eligibility criteria for the MTM program and who received a Comprehensive Medication Review (CMR) with a written summary in standardized CMS format.
- **Additional 2016 Star Ratings Measures**—CMS intends to return these measures to the 2016 Star Ratings
  - Breast Cancer Screening (Part C)
  - Call Center—Foreign Language Interpreter and TTY Availability Measures (Part C & D)
  - Beneficiary Access and Performance Problems (Part C & D)
- **Changes to Measures for 2016**—CMS is modifying methodology for the following measures:
  - Controlling Blood Pressure (Part C)
  - Plan Makes Timely Decisions about Appeals (Part C)
  - Plan All-Cause Readmissions (Part C)
  - Osteoporosis Management in Women who had a Fracture (Part C)
  - Complaints about the Health/Drug Program (CTM) (Part C & D)
  - Improvement Measures (Part C & D)
  - Appeals Auto-forward and Upheld Measures (Part D)
  - Medication Adherence (for Diabetes Medications and Hypertension (RAS antagonists)) and Diabetes Treatment (Part D)
  - Medication Adherence (Diabetes Medication, Hypertension (RAS antagonists), and for Cholesterol (Statins)) (Part D)
  - Obsolete NDCs (Part D)
  - CAHPS (Part C & D)
• Retirement of Measures – CMS is retiring the following measures, since they were retired from the 2015 HEDIS measurements:
  - Cardiovascular Care: Cholesterol Screening
  - Diabetes Care: Cholesterol Screening
  - Diabetes Care: Cholesterol Controlled

• Temporary Removal of Measures from Star Ratings – CMS is temporarily removing the following measure:
  - Improving Bladder Control (Part C)

• Contracts with Low Enrollment: Beginning with the 2016 Star Ratings, contracts with 500+ enrollees as of July 2014 will not be considered low enrollment contracts.

• Data Integrity: CMS will continue to reduce a contract’s measure rating to 1 star if biased or erroneous data is submitted. CMS proposes to expand use of the Part C and D data validation results as a new method of comprehensively reviewing sponsors’ operational systems, and verify the validity of some data used for Star Ratings.

• Duals/LIS: Multiple MAOs and PDP sponsors believe plans with a high percentage of Duals and/or LIS enrollees are disadvantaged in the current Star Ratings Program. CMS believes additional research into what is driving the differential performance is necessary before any permanent changes can be considered. In the interim, CMS proposes reducing the weights on the following measures:
  - Breast Cancer Screening (Part C)
  - Colorectal Cancer Screening (Part C)
  - Diabetes Care—Blood Sugar Controlled (Part C)
  - Osteoporosis Management in Women who had a Fracture (Part C)
  - Rheumatoid Arthritis Management (Part C)
  - Reducing the Risk of Falling (Part C)
  - Medication Adherence for Hypertension (Part D)

• Measures Posted on the CMS Display Page: Display measures on www.cms.gov are not part of the Star Ratings. Data on measures moved to the Display Page will continue to be collected and monitored, and poor scores on display measures are subject to compliance actions by CMS.

• Forecasting to 2017 and Beyond - CMS is considering the following changes for 2017 and beyond:
  - Changes to existing measures:
    o Changes to the Medication Reconciliation Post Discharge measure
    o CAHPS 5.0 changes: CMS will conduct an experiment in 2015 to understand if/how performance on CAHPS measures differ between 4.0 and 5.0.
    o Updates to the MPF Price Accuracy measure
  - Potential New Measures:
    o Care Coordination Measures
    o Asthma Measure Suite
    o Depression
    o Hospitalization for Potentially Preventable Complications
    o Statin Therapy
    o High Risk Medication
    o Opioid Overutilization

CMS welcomes additional feedback and suggestions to help CMS’ continuing analyses and collaboration with measurement development entities such as NCQA and PQA.
Audit and Oversight
Program & Compliance Plan Audit Performance: CMS strongly encourages plan sponsors to utilize the evaluation tools and information made available to proactively verify that organizations are compliant with CMS requirements.

New Program Audit Modules: CMS will pilot two new modules during 2015, testing compliance with Medication Therapy Management (MTM) and Provider Network Adequacy. These will be revised based on 2015 and made permanent for contract year 2016.

Integrated Dual-Eligible Special Needs Plans
CMS is working to promote integrated care for Medicare-Medicaid enrollees. CMS is using administrative flexibilities in a number of areas (i.e. marketing, regulatory oversight) to further these goals. In order to inform ongoing efforts, CMS requests comment on additional administrative flexibilities that may further these goals including the:

- Development of materials that better communicate the integrated benefit to the Medicare-Medicaid enrollee population.
- Enhanced coordination of state and CMS regulatory oversight.
- Integration of state quality-of-care priorities into the care delivered by highly integrated D-SNPs.

Seamless Conversion Enrollment Option: Entities that offer Medicaid Managed Care Organizations (MCOs) and also offer integrated D-SNPs can promote coverage of an integrated Medicare and Medicaid benefit through seamless conversion enrollment of Medicaid MCO members as they become eligible for Medicare.

Promoting Integrated D-SNPs: Both states and contracted D-SNPs can reach out to and inform Medicare-Medicaid enrollees of their option to enroll in D-SNPs that provide integrated Medicare and Medicaid benefits.

Benefit Flexibility for Highly Integrated, High Performing D-SNPs: CMS is interested in expanding the number of D-SNPs enrollees who could benefit from the flexibility of allowing high performing D-SNPs to offer supplemental benefits beyond those permitted for MA plans (e.g. non-skilled in-home support services, caregiver supports, etc.). CMS is using this draft Call Letter to remind D-SNPs and states of the availability of this flexibility.


Value-Based Contracting to Reduce Costs and Improve Health Outcomes
CMS is testing on a large scale a wide variety of new payment models including different types of accountable care organizations, bundled payments for episodes of care or related health care services, and primary care medical homes. The overall goal of these payment models is to improve quality of care and to reduce costs. CMS will be reaching out to and having conversations with MAOs regarding how they are using physician incentive payments and value-based contracting of provider services to achieve these goals.
Section II – Part C

Overview of 2016 Benefits and Bid Reviews

The following table shows applicable bid review criteria by plan type.

### Table 1. Plan Types and Applicable Bid Review Criteria

<table>
<thead>
<tr>
<th>Bid Review Criteria</th>
<th>Applies to Non-Employer Plans (Excluding Dual Eligible SNPs)</th>
<th>Applies to Non-Employer Dual Eligible SNPs</th>
<th>Applies to 1876 Cost Plans</th>
<th>Applies to Employer Plans</th>
</tr>
</thead>
<tbody>
<tr>
<td>Low Enrollment</td>
<td>Yes</td>
<td>Yes</td>
<td>No</td>
<td>No</td>
</tr>
<tr>
<td>Meaningful Difference</td>
<td>Yes</td>
<td>Yes</td>
<td>No</td>
<td>No</td>
</tr>
<tr>
<td>Total Beneficiary Cost</td>
<td>Yes</td>
<td>No</td>
<td>No</td>
<td>No</td>
</tr>
<tr>
<td>Maximum Out-of-Pocket (MOOP) Limits</td>
<td>Yes</td>
<td>Yes</td>
<td>No</td>
<td>Yes</td>
</tr>
<tr>
<td>PMPM Actuarial Equivalent Cost Sharing</td>
<td>Yes</td>
<td>Yes</td>
<td>No</td>
<td>Yes</td>
</tr>
<tr>
<td>Service Category Cost Sharing</td>
<td>Yes</td>
<td>Yes</td>
<td>Yes¹</td>
<td>Yes</td>
</tr>
<tr>
<td>Part C Optional Supplemental Benefits</td>
<td>Yes</td>
<td>Yes</td>
<td>No</td>
<td>No</td>
</tr>
</tbody>
</table>

¹ MA plans and 1876 Cost Plans may not charge enrollees higher cost sharing than is charged under Original Medicare for chemotherapy administration, skilled nursing care and renal dialysis services (42 CFR §§417.454(e) and 422.100(i)).

**Low Enrollment Plans**

- CMS will contact MAO’s to identify all low enrollment plans (<500 enrollees in non-SNP plans in existence for at least three years) as of March 2015
- Like last year, such plans must then:
  - Be eliminated, or
  - Consolidated with another of the organization’s plans, or
  - Be justified via submission of such justification to CMS

**Meaningful Differences**

- Like last year, CMS will consider HMO and HMO-POS as the same plan type for meaningful difference testing, unless the HMO-POS plan covers all Parts A and B services outside the network
- The 2015 Draft Call Letter explained that CMS was considering requiring HMO-POS plans to not place geographic or provider limitations on the out-of-network benefits in order to be considered meaningfully different from HMO. This is not being implemented in 2016, but may be in future years.
- For CY 2017, CMS is considering applying the meaningful difference evaluation at the “legal entity”/MAO level rather than the “contract” level. They are also considering ultimately broadening to the “parent organization level”.
- CMS will evaluate meaningful differences for the among plans offered in the same county, and under the same contract, as follows:
  - HMO and HMO-POS not offering all Parts A and B services out-of-network; HMO POS offering all Parts A and B services out-of-network; Local PPO; Regional PPO; and PFFS evaluated separately
- Chronic and Institutional SNPs will be divided based on the populations served. Dual SNPs excluded.
- MA only evaluated separately from MA-PD
- Must be a combined Part C and D OOPC difference of at least $20 PMPM. Neither plan premium or provider networks are included in the meaningful difference evaluation.
  - CMS may choose not to allow a plan to revise its bids if it doesn’t comply with meaningful difference in initial bid submission.

Total Beneficiary Cost (TBC)
- CMS may deny bids that propose too significant an increase in cost sharing or decrease in benefits
- TBC = Plan-specific Part B premium + Plan Premium + Estimated beneficiary OOP costs
- CMS will continue to use a TBC standard of $32 PMPM as in CY 2015
- CMS proposes modifications to the threshold based on increases or decreases in Quality Incentive Payments as follows:
  - Plans with an increase in quality bonus payment and/or rebate percentage that have an overall TBC change of more than $32 will have a “deemed” TBC change of -1 times the TBC limit (plus applicable adjustments)
  - Plans with a decrease in quality bonus payments and/or rebate percentage and plans with a star rating below 3.0 that have an overall TBC change of less than -$32 will have a “deemed” TBC change of 2 times the TBC limit (plus applicable adjustments).
- CMS will continue to incorporate adjustments in TBC threshold for plan’s payment rate, quality bonus change, the national MA coding pattern change, and other technical adjustments
- Consolidating plans will be evaluated on enrollment weighted average of CY2015 plan values
- For CMS 2017, CMS intends to “discount” the plan-specific adjustment for both increases and decreases in payments.

Maximum Out-of-Pocket Limits
- 2016 MOOP limits are the same as 2015 (generally $3400 for in-network services at the “voluntary” level; $6400 for in-network services at the “mandatory” level). The 2016 MOOP limits by plan type are shown in Exhibit C at the end of this summary.
- Although it may be rare that a dual-eligible enrollee would be responsible for paying any cost sharing, all MA plans must track enrollees’ actual out-of-pocket spending for covered services in order to make certain an enrollee does not spend more than the MOOP amount limit established by the plan.

Actuarial Equivalent Cost Share: CMS will continue to require PMPM actuarial equivalent cost sharing limits. 2016 PMPM actuarial equivalent cost sharing maximum examples are shown in Exhibit C at the end of this summary.

Service Category Cost Sharing Requirements
- IP, SNF and Emergency Care amounts have been updated
- Exhibit C at the end of this summary shows the 2016 cost sharing limits by service category.

Part C Optional Supplemental Benefits
- Plans must ensure that the total value of all optional supplemental benefits meet the following:
  - Margin <= 15%
  - Margin + Admin <= 30%
PBP Updates and Guidance
Currently, the same medical service may be entered in multiple PBP service categories. CMS intends to ultimately adjust selected PBP service categories to reflect the services provided across a variety of different places of service. Cost sharing for a given service should be reflected in one PBP service category only, with the minimum/maximum data fields referring to varying places of service.

CMS intends to make these changes over the next two years. In CY 2016, the following service categories are to reflect cost sharing for services provided in all outpatient settings:

<table>
<thead>
<tr>
<th>PBP Sec. B</th>
<th>Service Category</th>
</tr>
</thead>
<tbody>
<tr>
<td>3</td>
<td>Cardiac and Pulmonary Rehabilitation Services</td>
</tr>
<tr>
<td>7a</td>
<td>Primary Care Physician Services</td>
</tr>
<tr>
<td>7d</td>
<td>Physician Specialist Services excluding Psychiatric Services</td>
</tr>
<tr>
<td>7f</td>
<td>Podiatry Services</td>
</tr>
<tr>
<td>9d</td>
<td>Outpatient Blood Services</td>
</tr>
<tr>
<td>11b</td>
<td>Prosthetics/Medical Supplies</td>
</tr>
<tr>
<td>12</td>
<td>End-Stage Renal Disease</td>
</tr>
<tr>
<td>14a</td>
<td>Medicare-Covered Zero Cost-Sharing Preventive Services</td>
</tr>
<tr>
<td>15</td>
<td>Medicare Part B Rx Drugs and Home Infusion Drugs</td>
</tr>
</tbody>
</table>

Additional similar changes are proposed for CY 2017.

Tiered Cost Sharing of Medical Benefits
CMS is revising the PBP so that MAOs can more clearly describe their tiered benefit structure using data entry.

Part C Policy Updates
CMS is proposing the following policy updates:

Part C Emergency/Urgently Needed Services Deductible Guidance:
CMS is proposing to eliminate the stipulation that all cost sharing associated with Emergency Care/Urgently Needed Services apply toward any-plan level deductible; thereby separating these services from the plan level deductible entirely.

Annual Physical Exam Supplemental Benefit: MA plans may offer Annual Physical Exams as mandatory supplemental benefits. These are defined as being performed by a qualified physician (or non-physician practitioner) and including a detailed medical/family history and the performance of a detailed head to toe assessment with hands-on examination of all body systems.
Exceptions to Policies Permitting Plans to Limit Durable Medical Equipment (DME) to Certain Brands and Manufacturers:

- Speech-generating devices may not be subject to full limitation
- The following may be subject to partial limitation:
  1. Oxygen
  2. Wheelchairs
  3. Powered Mattress systems
  4. Diabetic supplies

Contract Consolidations: CMS encourages MAOs operating more than one MA-PD contract of the same product type under the same legal entity to consolidate these contracts under a single contract ID for contract year CY 2016.

Limiting Applications: CMS reminds existing organizations that they will not assign a new contract ID to existing legal entities for product types they currently contract with CMS. If an organization would like to offer a SNP and they currently hold an HMO/HMOPOS contract they can submit a SNP Proposal to offer that plan type under the existing HMO contract. They can’t operate a SNP as a separate HMO contract from their existing HMO contract.

MA/MA-PD Application Change: CMS explains that new applicants may submit a request to waive the enrollment requirement. CMS regulations allow CMS to waive the minimum enrollment requirement during an organization’s first three years of operation. CMS has developed a minimum enrollment waiver request attestation and a minimum enrollment waiver request template for CY 2016.

Two-year Prohibition: CMS adopted a final rule to expand application of the two-year prohibition on re-entering the MA program in the event that a previous contract was terminated at the request of the organization within the receding two-year period. It was expanded to avoid:

- Unnecessarily narrowing the scope of the two-year prohibition, or
- Precluding CMS from preventing poor performance MA organizations from reentering the MA program.

Guidance to Verify that Networks are Adequate and Provider Directories are Current:
CMS is receiving complaints regarding the inaccuracy of online provider directories. They explain that they may view inaccurate provider directories as an indication that the MAO may be failing established CMS standards. They are implementing a three-pronged approach to monitor compliance the regulations, including:

- Direct monitoring
- Development of a new audit protocol, and
- Compliance and/or enforcement actions.

Guidance for Off-Cycle Submission of Summaries of MOC Changes:
CMS expects that SNP MOC changes should be relatively rare, but when necessary they should submit a summary of the pertinent modifications to the approved MOC in HPMS. This HPMS module will be available later in 2015. Until then, SNPs should document any changes to their MCOs and notify CMS of those revisions as they do now.
Waiver of the Three Day Qualifying Inpatient Hospital Stay: CMS clarifies that the waiver of the three day hospital stay and the associated SNF stay are basic benefits and must be entered as such in both the PBP and the BPT.

Standardizing the Health Risk Assessment (HRA): CMS encourages MAOs to adopt the components in the CDC Model HRA beginning in CY 2016. CMS is considering requiring a standardized HRA for use by all SNPs in the future.

Guidance for In-Home Enrollee Risk Assessments: CMS believes that in-home assessments can have significant value, but is concerned that they are primarily being used to collect diagnoses that increase risk adjusted payments. They propose a two-pronged approach – providing guidance on best practices for conducting in-home assessments and tracking subsequently provided care. The guidance states that an in-home assessment should include the following:
- All components of the annual wellness visit
- Medication review and reconciliation
- Scheduling appointments with appropriate providers and making referrals
- Conducting an environmental scan of enrollee’s home for safety risks
- A process to verify that needed follow-up care is provided
- A process to verify that information obtained is provided to appropriate plan providers
- Provision to the enrollee of a summary of the information
- Enrollment of assessed enrollees into plan’s disease management/case management programs, as appropriate.

Cost Contract Provisions

Cost Plan Application
Plans are reminded that CMS will not accept any new cost plan applications. Applications to modify cost plan contracts to expand service areas will continue to be accepted.

Closing Cost Plans to New Enrollment when a Related Entity is Operating in Same Service Area
CMS reminds MAOs that the cost plan enrollment requirements were revised because, contrary to their intent, they previously permitted legal entities that are related to each other under a common parent organization to offer a cost contract and MA plan in the same service area. This is not permitted now.

Cost Contract Plan Competition Requirements
- CMS will not renew cost plans in service areas or portions of service areas where at least two competing MA local or two MA regional plans that meet certain enrollment thresholds are available.
- Non-renewed contractors will not be able to operate in impacted services areas in 2017.
- Cost plans may still offer a mid-year service area expansion.
Section III – Part D

Improving Drug Utilization Review Controls in Medicare Part D

Background

Beginning January 1, 2013, CMS expectations of Sponsors were:
1. Improve safety at Point of Sale (POS), in particular with respect to acetaminophen (APAP)
2. Detect cases of opioid overutilization and apply case management principles through
   implementation of improved drug utilization review following CMS guidance.
   a. Beneficiary POS claim edits may be used to prevent continued overutilization
   b. POS claim edits are shared with a new sponsor if the beneficiary moves to another plan.

CMS steps to ensure effective implementation
1. Launch of the Overutilization Monitoring System (OMS)
   a. Provides quarterly reports to sponsors on potential overutilization based on the
      previous 12-months of PDE data
   b. Sponsors must respond to OMS within 30-days on review of identified cases
2. January 2014 enhancement – includes beneficiaries identified by sponsors (outside OMS).
3. February 2014 enhancement – MARx system allows beneficiary specific data on potential
   overutilization for the purpose of alerting new plans should the beneficiary move.

Results that Impact 2016

Over 80,000 potential overutilization cases were identified. Repeat cases of potential APAP
overutilization dropped and the repeat cases of potential opioid overutilization increased during the
third quarter of 2014.

In light of these findings CMS proposes the following:

APAP – Soft formulary level edits were implemented in 2015 to reduce overutilization of APAP. CMS has
identified hard edits that may be required in 2016. CMS is NOT requiring the implementation of the
hard edits in 2016 but expecting sponsors to continue with the soft edits from 2015 and to monitor
APAP utilization.

OPIOIDS – For 2016, Part D sponsors should implement soft formulary level POS edits based on
cumulative daily morphine equivalent does (MED) to reduce opioid overutilization. CMS expects
Pharmacy and therapeutics (P&T) committees to develop criteria for the POS edits to prevent opioid
overutilization while minimizing false positives. Comments from sponsors are requested on the limits
presented on pages 145-146 of the call letter.

Potential revisions/enhancements to OMS and MARx considered for 2016
1. Contract-level and contract-type average high-dose opioid and APA utilization rates reported to
   sponsors
2. New measures based on potentially unsafe use of opioids
**Medication Therapy Management (MTM)**
Annual MTM eligibility cost threshold for 2015 was $3,138. The amount for 2016 will be released in the 2016 call letter, and is proposed to be the 2015 amount adjusted based on the annual percentage.

**Access to Preferred Cost-Sharing Pharmacies**
In an effort to verify beneficiaries have access to preferred cost sharing pharmacies (PCSPs) and the lower cost sharing that associated with and advertised by plans, CMS is taking a 2-pronged approach to ensuring beneficiaries are properly informed:
- CMS will publish information on PCSP access levels for plans offering preferred cost sharing.
- During bid review and negotiation, CMS will work with outlier plans (the bottom 10th percentile) to either increase access to the PCSPs or prevent plans from marketing themselves as offering preferred cost sharing in the affected areas.

**Part D Benefit Parameters for Non-Defined Standard Plans**

**Tier Labeling**
CMS proposes that the tier labeling for generic tiers will change in 2016. The generic and non-preferred generic tiers will be merged into one “generic” tier, with the option of having a preferred generic tier with lower cost sharing for a subset of generic drugs.

In addition, CMS reminds sponsors that while not prohibited from having a mix of brand and generic drugs on the same tier, the drug tier label should be representative of the drugs that largely make up that tier.

Sponsors are also reminded that in the coverage gap, the maximum coinsurance of 65% applies to tiers that contain only applicable drugs. If non-applicable drugs or a combination of both non-applicable and applicable drugs are on a tier, then the maximum coinsurance of 38% applies.

**Benefit Review**
Part D plans that contain coinsurance values that are greater than 25% on non-specialty tiers will continue to be checked against the copay thresholds by using the average copayment amount.

$0 or very low cost sharing for mail service continues to be disallowed unless offering the same cost sharing at retail pharmacies.

**Benefit Parameters**
CMS expects plan sponsors to follow these parameters on non-DS PD plans:
- Cost sharing be set at $0 for all dedicated Vaccine tiers
- Cost sharing be set at $0 for Select Care/Select Diabetes Drug Tiers that contain vaccine products
The following table presents the 2016 Part D benefit parameters:

<table>
<thead>
<tr>
<th>Minimum Meaningful Differences (PDP Cost-Sharing OOPC)</th>
<th>CY2016 Threshold Values</th>
</tr>
</thead>
<tbody>
<tr>
<td>Enhanced Alternative Plan vs. Basic Plan</td>
<td>$18</td>
</tr>
<tr>
<td>Enhanced Alternative Plan vs. Enhanced Alternative Plan</td>
<td>$30</td>
</tr>
<tr>
<td>Maximum Copay: Pre-ICL and Additional Cost-Sharing Reductions in the Gap (3 or more tiers)</td>
<td></td>
</tr>
<tr>
<td>Preferred Generic Tier</td>
<td>&lt;$15</td>
</tr>
<tr>
<td>Generic Tier</td>
<td>$15</td>
</tr>
<tr>
<td>Preferred Brand/Brand Tier</td>
<td>$47</td>
</tr>
<tr>
<td>Non-Preferred Brand Tier</td>
<td>$100</td>
</tr>
<tr>
<td>Injectable Tier</td>
<td>$100</td>
</tr>
<tr>
<td>Select Care/Diabetic Tiers4</td>
<td>$11</td>
</tr>
<tr>
<td>MaximumCoinsurance: Pre-ICL (3 or more tiers)</td>
<td></td>
</tr>
<tr>
<td>Preferred Generic Tier</td>
<td>25%</td>
</tr>
<tr>
<td>Generic Tier</td>
<td>25%</td>
</tr>
<tr>
<td>Preferred Brand/Brand Tier</td>
<td>25%</td>
</tr>
<tr>
<td>Non-Preferred Brand Tier</td>
<td>50%</td>
</tr>
<tr>
<td>Injectable Tier</td>
<td>33%</td>
</tr>
<tr>
<td>Select Care/Diabetic Tiers4</td>
<td>15%</td>
</tr>
<tr>
<td>Maximum Coinsurance: Additional Cost-Sharing Reductions in the Gap for Applicable Beneficiaries (all tier designs)</td>
<td></td>
</tr>
<tr>
<td>Preferred Generic Tier</td>
<td>38%</td>
</tr>
<tr>
<td>Generic Tier</td>
<td>38%</td>
</tr>
<tr>
<td>Preferred Brand/Brand Tier</td>
<td>65%</td>
</tr>
<tr>
<td>Non-Preferred Brand Tier</td>
<td>65%</td>
</tr>
<tr>
<td>Injectable Tier</td>
<td>65%</td>
</tr>
<tr>
<td>Select Care/Diabetic Tiers4</td>
<td>65%</td>
</tr>
<tr>
<td>Minimum Specialty Tier Eligibility</td>
<td></td>
</tr>
<tr>
<td>1-month supply at in-network retail pharmacy</td>
<td>$600</td>
</tr>
</tbody>
</table>

The specialty tier eligibility remains at $600. The cost sharing is restricted to no more than permitted under the defined standard plan (25%) if the plan requires a Part D standard deductible and to 33% if no deductible is required (the percentage is pro-rated for decreased deductibles). CMS noted that the decreased on zero deductible must apply to all tiers, not just the specialty tier.

Note, for 2017 CMS may institute a Total Beneficiary Cost (TBC) measure for PDPs.

**Maximum Allowable Cost (MAC) Pricing**
Updates to MAC prices must be disclosed to network pharmacies timely and in a manner usable by pharmacies so the pharmacies may validate prices.
Mail Order and Changes to Applying for Exceptions to the Auto-Ship Policy
As of January 1, 2016 Part D sponsors offering automatic delivery of new prescriptions will no longer need to request an exception from CMS. In addition, as of January 1, 2016 Employer Group Waiver Plans (EGWP) will no longer need to request an exception to the CMS Auto-Ship policy.

Beneficiaries may be contacted directly for the initial auto-shipment. The beneficiary should have an easy opt-out option if they choose not to use the auto-shipment option.

Coordination of Benefit (COB) User Fee (should be included in the Part D bids)
The 2016 Part D COB user fee will be $0.116 for the 1st 9 months of the coverage year which equates to $0.087 per enrollee per month or $1.05 per enrollee per year.

Part D Low Enrollment
Plan sponsors are urged to voluntarily withdraw or consolidate any stand-alone plan with less than 1,000 enrollees. By April 2015, CMS will notify plans with less than 1,000 enrollees of consolidation or withdrawal options.
Appendices

Appendix I: Contract Year 2016 Guidance for Prescription Drug Plan (PDP) Renewals and Non-Renewals

- CMS has defined 34 separate PDP regions; refer to the Prescription Drug Benefit Manual for a map of the regions. PDP sponsors must submit separate bids for each region to be covered.
- If a sponsor wishes to expand the service area of its offerings, it must submit a PDP Service Area Expansion (SAE) application to CMS for approval.
- If a sponsor wishes to reduce its service area, it may elect not to submit bids for the regions from which it expects to withdraw. The sponsor must notify CMS in writing by sending an email to nonrenwals@cms.hhs.gov by June 1, 2015.

The following renewal/non-renewal options available for CY2016 are listed below.

1. New Plan Added
2. Renewal Plan
3. Consolidated Renewal Plan
4. Renewal Plan with a Service Area Expansion (“800 Series EGWPs only)
5. Terminated Plan (Non-Renewal)
6. Consolidated Plans under a Parent Organization

Appendix II: Contract Year 2016 Guidance for Prescription Drug Plan (PDP) Renewals and Non-Renewals Table

Appendix II provides detailed guidance on each of the renewal/non-renewal options available for CY2016.

Appendix III: Beneficiary Access and Performance Problems (Revised Methodology)

CMS has revised some definitions and the methodology for the Beneficiary Access and Performance Problems quality measure.

Appendix IV: Improvement Measures (Part C & D)

Appendix IV lists the quality measures that are considered improvement measures.
Exhibit A - Wakely Estimated Impact of Growth Rates combined with Payment Reform

Wakely estimates that, on a nationwide average basis, risk-adjusted Part C benchmarks will decrease by 3.0% in 2016 as compared with 2015. This is comparable to the CMS estimate of -0.9%. The Wakely estimate is based on the following components:

- Change in blended benchmarks
- Change in HCC model blend (100% 2014 HCC for CY2016 vs. 67%/33% 2013 HCC/2014 HCC in CY2015).
- Impact of change in fee-for-service normalization factor
- Change in coding pattern difference adjustment
- Assumption of no trend in raw risk scores

The actual revenue change for individual Medicare Advantage plans will depend on the trend in bids, and will further vary depending on star rating, counties served, risk score trends, population changes, and many other factors.

If we assume that bids increase by 1%, then we estimate the change in Part C payments from 2015 to 2016 to be a decrease of 1.4%.

Table 1 shows our estimates of the components that make up this change:

| Table 1                                                                 |
|---------------------------------------------------------------|-----------------|
| Change in Blended Benchmarks [1]                              |
| 2015 to 2016                                                   |
| Growth Rate                                                   | 1.6%            |
| Applicable %                                                   | 0.3%            |
| Star Rating/Quality Bonus                                      | 0.8%            |
| Payment Reform Transition                                      | -0.8%           |
| Benchmark Cap                                                  | 0.1%            |
| **Total Benchmark Change**                                     | **1.9%**        |
| HCC Blend                                                      | -4.1%           |
| FFS Normalization                                              | -0.5%           |
| Coding Pattern Difference                                      | -0.3%           |
| **Total Risk Score Change**                                    | **-4.8%**       |
| **TOTAL**                                                      | **-3.0%**       |

Below is a brief definition of each of the elements in Table 1.

**Growth Rate.** Blend of the 2016 NPCMGP (+2.68%) and FFS (+1.47%) growth rates.

**Applicable %**. Average nationwide change in applicable percentage, based on the enrollment by Medicare Advantage contract and county.

**Star Rating/Quality Bonus.** Difference in quality bonus impact on benchmarks between 2015 and 2016. This can be due to star rating improvements for MA plans from 2015 to 2016 as well as changing enrollment mix by MA plan.
**Transition.** Impact of the changing blend of pre-ACA and FFS rates by county. For 2016, only six-year transition counties are affected.

**Benchmark Cap.** The ACA formula requires that the final blended benchmark can be no greater than the pre-ACA benchmark. The impact of this cap can year-to-year as plans change star ratings, and as the NPCMGP trend differs from the FFS trend.

**HCC Blend.** For CY2016, CMS has proposed a full transition to the 2014 HCC model. In 2015, CMS is using a 67%/33% blend of the 2013 HCC/2014 HCC models. CMS estimates that the net impact of this change in blend is -1.7%, implying that the 2014 HCC model produces risk scores about 2.5% lower than the 2013 HCC model for a given population. Based on Wakely clients, the 2014 HCC models produce a risk score that is on average 6% below the 2013 HCC model, which implies a net impact of -4.1%. This calculation is shown below.

<table>
<thead>
<tr>
<th>HCC Model</th>
<th>Risk Score Relativity</th>
<th>Blend</th>
</tr>
</thead>
<tbody>
<tr>
<td>2014</td>
<td>0.959</td>
<td>0.33</td>
</tr>
<tr>
<td>2013</td>
<td>1.020</td>
<td>0.67</td>
</tr>
<tr>
<td>Composite</td>
<td>1.000</td>
<td>1.00</td>
</tr>
</tbody>
</table>

**Impact = 0.959-1 = -4.1%**

**Part C Fee-for-Service (FFS) Normalization Factor.** The 2015 Part C FFS normalization factor is a 67%/33% blend of the 2013/2014 factors of 0.992 and 0.978, respectively. For CY2016, the FFS normalization factor is proposed to be 0.992. Calculating the change between the blended 2015 factor and the proposed 2016 factor, the impact is -0.47%, as shown below.

<table>
<thead>
<tr>
<th>HCC Model</th>
<th>2016 FFS Normalization Factor</th>
<th>2015 FFS Normalization Factor</th>
<th>2016/2015</th>
</tr>
</thead>
<tbody>
<tr>
<td>2014</td>
<td>0.992</td>
<td>0.978</td>
<td>-0.47%</td>
</tr>
<tr>
<td>2013</td>
<td>0.992</td>
<td>0.992</td>
<td>0.00%</td>
</tr>
<tr>
<td>Blend [1]</td>
<td>0.992</td>
<td>0.987</td>
<td>-0.47%</td>
</tr>
</tbody>
</table>


**Change in Coding Pattern Adjustment.** The coding pattern adjustment for 2015 will be -5.41%, which is the minimum adjustment required by the Affordable Care Act. This represents a reduction of 0.25% as compared with 2015.

**Change in Bid and Rebate Amounts**
In order to properly estimate the impact of the various MA payment components addressed in the Advance Notice, Medicare Advantage plans must consider the aggregate effect on actual payments from CMS, which is not necessarily the same as the change in benchmarks. As noted above, we estimate the overall impact to MA payments to be -1.4%, after taking bid levels and rebates into account. This estimate is based on the following assumptions:
- Plans bid at 80% of the benchmark in 2015
- Bid trend from 2015 to 2016 will be 1% assuming a static population
- Annual risk score coding trend is 0% for a static population
• Nationwide average star ratings, which result in an average rebate percentage of 64% in 2015 and 65.8% for 2016.
• No consideration for sequestration or insurer fee

The table on the following page shows the calculations underlying our estimates.

<table>
<thead>
<tr>
<th></th>
<th>2015</th>
<th>2016</th>
<th>2016/2015</th>
</tr>
</thead>
<tbody>
<tr>
<td>1.0 MA Benchmark [1]</td>
<td>$787.56</td>
<td>$802.61</td>
<td>1.9%</td>
</tr>
<tr>
<td>Raw MA Risk Adjustment Factor [2]</td>
<td>1.000</td>
<td>1.000</td>
<td></td>
</tr>
<tr>
<td>HCC Change</td>
<td>1.000</td>
<td>0.959</td>
<td></td>
</tr>
<tr>
<td>FFS Normalization Factor</td>
<td>0.987</td>
<td>0.992</td>
<td></td>
</tr>
<tr>
<td>Coding Pattern Difference</td>
<td>0.948</td>
<td>0.946</td>
<td></td>
</tr>
<tr>
<td>RAF after FFS Norm &amp; Coding Pattern</td>
<td>0.961</td>
<td>0.914</td>
<td></td>
</tr>
<tr>
<td>Risk-adjusted Benchmark</td>
<td>$756.46</td>
<td>$733.93</td>
<td>-3.0%</td>
</tr>
<tr>
<td>Risk-adjusted Bid [3]</td>
<td>$605.17</td>
<td>$611.22</td>
<td>1.0%</td>
</tr>
<tr>
<td>Savings</td>
<td>$151.29</td>
<td>$122.70</td>
<td></td>
</tr>
<tr>
<td>Rebate</td>
<td>$96.83</td>
<td>$80.72</td>
<td></td>
</tr>
</tbody>
</table>

Total CMS Payment | $702.00 | $691.94 | -1.4%

[1] Based on nationwide average MA enrollment by county as of February 2015 and star ratings by year
[2] Assume no trend in risk scores
[3] Assumes plans bid 80% of benchmark and a 1% trend in bids from 2015 to 2016

As in past years, CMS did not release county-specific benchmarks that reflect re-basing. The re-basing that CMS intends to perform prior to the Final Rate Announcement may result in dramatically different changes in FFS benchmarks by county.
# Exhibit B – CY2016 Part D Defined Standard Benefit Parameters

## Part D Benefit Parameters

<table>
<thead>
<tr>
<th>Standard Benefit</th>
<th>2015</th>
<th>2016</th>
</tr>
</thead>
<tbody>
<tr>
<td>Deductible</td>
<td>$320</td>
<td>$360</td>
</tr>
<tr>
<td>Initial Coverage Limit</td>
<td>$2,960</td>
<td>$3,310</td>
</tr>
<tr>
<td>Out-of-Pocket Threshold</td>
<td>$4,700</td>
<td>$4,850</td>
</tr>
<tr>
<td>Total Covered Part D Spending at Out-of-Pocket Threshold for Non-Applicable Beneficiaries (2)</td>
<td>$6,680.00</td>
<td>$7,062.50</td>
</tr>
<tr>
<td>Estimated Total Covered Part D Spending for Applicable Beneficiaries (3)</td>
<td>$7,061.76</td>
<td>$7,515.22</td>
</tr>
<tr>
<td>Minimum Cost-Sharing in Catastrophic Coverage Portion of the Benefit</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Generic/Preferred Multi-Source Drug</td>
<td>$2.65</td>
<td>$2.95</td>
</tr>
<tr>
<td>Other</td>
<td>$6.60</td>
<td>$7.40</td>
</tr>
</tbody>
</table>

## Full Subsidy-Full Benefit Dual Eligible (FBDE) Individuals (5)

<table>
<thead>
<tr>
<th>Standard Benefit</th>
<th>2015</th>
<th>2016</th>
</tr>
</thead>
<tbody>
<tr>
<td>Deductible</td>
<td>$0.00</td>
<td>$0.00</td>
</tr>
<tr>
<td>Copayments for Institutionalized Beneficiaries (category code 3)</td>
<td>$0.00</td>
<td>$0.00</td>
</tr>
<tr>
<td>Copayments for Beneficiaries Receiving Home and Community-Based Services (4) (category code 3)</td>
<td>$0.00</td>
<td>$0.00</td>
</tr>
<tr>
<td>Maximum Copayments for Non-Institutionalized Beneficiaries</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Up to or at 100% FPL (category code 2)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Up to Out-of-Pocket Threshold (1)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Generic/Preferred Multi-Source Drug</td>
<td>$1.20</td>
<td>$1.20</td>
</tr>
<tr>
<td>Other (4)</td>
<td>$3.60</td>
<td>$3.60</td>
</tr>
<tr>
<td>Above Out-of-Pocket Threshold</td>
<td>$0.00</td>
<td>$0.00</td>
</tr>
<tr>
<td>Over 100% FPL (category code 1)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Up to Out-of-Pocket Threshold</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Generic/Preferred Multi-Source Drug</td>
<td>$2.65</td>
<td>$2.95</td>
</tr>
<tr>
<td>Other</td>
<td>$6.60</td>
<td>$7.40</td>
</tr>
<tr>
<td>Above Out-of-Pocket Threshold</td>
<td>$0.00</td>
<td>$0.00</td>
</tr>
</tbody>
</table>

## Full Subsidy-Non-FBDE Individuals

Eligible for QMB/SLMB/QI, SSI or applied and income at or below 135% FPL and resources ≤ $8,780 (individuals) or ≤ $13,930 (couples) (6) (category code 1)

<table>
<thead>
<tr>
<th>Standard Benefit</th>
<th>2015</th>
<th>2016</th>
</tr>
</thead>
<tbody>
<tr>
<td>Deductible</td>
<td>$0.00</td>
<td>$0.00</td>
</tr>
<tr>
<td>Maximum Copayments up to Out-of-Pocket Threshold</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Generic/Preferred Multi-Source Drug</td>
<td>$2.65</td>
<td>$2.95</td>
</tr>
<tr>
<td>Other</td>
<td>$6.60</td>
<td>$7.40</td>
</tr>
<tr>
<td>Maximum Copayments above Out-of-Pocket Threshold</td>
<td>$0.00</td>
<td>$0.00</td>
</tr>
</tbody>
</table>
### Partial Subsidy

<table>
<thead>
<tr>
<th></th>
<th>2015</th>
<th>2016</th>
</tr>
</thead>
<tbody>
<tr>
<td>Applied and income below 150% FPL and resources below $13,640 (individual) or $27,250 (couples)</td>
<td>66.00</td>
<td>74.00</td>
</tr>
<tr>
<td>Deductible</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Coinsurance up to Out-of-Pocket Threshold</td>
<td>15%</td>
<td>15%</td>
</tr>
<tr>
<td>Maximum Copayments above Out-of-Pocket Threshold</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Generic/Preferred Multi-Source Drug</td>
<td>2.65</td>
<td>2.95</td>
</tr>
<tr>
<td>Other</td>
<td>6.60</td>
<td>7.40</td>
</tr>
</tbody>
</table>

### Retiree Drug Subsidy Amounts

<table>
<thead>
<tr>
<th></th>
<th>2015</th>
<th>2016</th>
</tr>
</thead>
<tbody>
<tr>
<td>Cost Threshold</td>
<td>$320</td>
<td>$360</td>
</tr>
<tr>
<td>Cost Limit</td>
<td>$6,600</td>
<td>$7,400</td>
</tr>
</tbody>
</table>

(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 (CPP) reported on prescription drug event (PDE) 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 (CPP) reported on prescription drug event (PDE) 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 increase 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 2016.
### Exhibit C – MA MOOP and Cost Sharing Limit Tables

<table>
<thead>
<tr>
<th>Plan Type</th>
<th>Voluntary</th>
<th>Mandatory</th>
</tr>
</thead>
<tbody>
<tr>
<td>HMO</td>
<td>$0 - $3,400</td>
<td>$3,401 - $6,700</td>
</tr>
<tr>
<td>HMO POS</td>
<td>$0 - $3,400 In-network</td>
<td>$3,401 - $6,700 In-network</td>
</tr>
<tr>
<td>Local PPO</td>
<td>$0 - $3,400 In-network and $0 - $5,100 Combined</td>
<td>$3,401 - $6,700 In-network and $3,401 - $10,000 Combined</td>
</tr>
<tr>
<td>Regional PPO</td>
<td>$0 - $3,400 In-network and $0 - $5,100 Combined</td>
<td>$3,401 - $6,700 In-network and $3,401 - $10,000 Combined</td>
</tr>
<tr>
<td>PFFS (full network)</td>
<td>$0 - $3,400 Combined</td>
<td>$3,401 - $6,700 Combined</td>
</tr>
<tr>
<td>PFFS (partial network)</td>
<td>$0 - $3,400 Combined</td>
<td>$3,401 - $6,700 Combined</td>
</tr>
<tr>
<td>PFFS (non-network)</td>
<td>$0 - $3,400</td>
<td>$3,401 - $6,700</td>
</tr>
</tbody>
</table>

### Illustrative Comparison of Service-Level Actuarial Equivalent Costs to Identify Excessive Cost Sharing

<table>
<thead>
<tr>
<th>BPT Benefit Category</th>
<th>#1 Original PMPM Plan Cost Sharing (Parts A&amp;B) (BPT Col. l)</th>
<th>#2 Original Medicare Allowed (BPT Col. m)</th>
<th>#3 Original Medicare AE Cost Sharing (BPT Col. n)</th>
<th>#4 Part B Adjustment Factor to Incorporate Part B Cost Sharing (Based on FFS data)</th>
<th>#5 Comparison Amount (#3 × #4)</th>
<th>#6 Excess Cost Sharing (#1 - #5, min of $0)</th>
<th>#7 Pass/Fail</th>
</tr>
</thead>
<tbody>
<tr>
<td>Inpatient</td>
<td>$33.49</td>
<td>$331.06</td>
<td>$25.30</td>
<td>1.397</td>
<td>$35.34</td>
<td>$0.00</td>
<td>Pass</td>
</tr>
<tr>
<td>SNF</td>
<td>$10.83</td>
<td>$58.19</td>
<td>$9.89</td>
<td>1.068</td>
<td>$10.56</td>
<td>$0.27</td>
<td>Fail</td>
</tr>
<tr>
<td>DME</td>
<td>$3.00</td>
<td>$11.37</td>
<td>$2.65</td>
<td>1.000</td>
<td>$2.65</td>
<td>$0.35</td>
<td>Fail</td>
</tr>
<tr>
<td>Part B-Rx</td>
<td>$0.06</td>
<td>$1.42</td>
<td>$0.33</td>
<td>1.000</td>
<td>$0.33</td>
<td>$0.00</td>
<td>Pass</td>
</tr>
</tbody>
</table>

1. PMPM values in column 3 for Inpatient and Skilled Nursing Facility only reflect Part A fee-for-service actuarial equivalent cost sharing for that service category.
## 2016 In-Network Service Category Cost Sharing Requirements

<table>
<thead>
<tr>
<th>Service Category</th>
<th>PBP Section B data entry field</th>
<th>Voluntary MOOP</th>
<th>Mandatory MOOP</th>
</tr>
</thead>
<tbody>
<tr>
<td>Inpatient - 60 days</td>
<td>1a</td>
<td>N/A</td>
<td>$4,209</td>
</tr>
<tr>
<td>Inpatient - 10 days</td>
<td>1a</td>
<td>$2,444</td>
<td>$1,955</td>
</tr>
<tr>
<td>Inpatient - 6 days</td>
<td>1a</td>
<td>$2,218</td>
<td>$1,774</td>
</tr>
<tr>
<td>Mental Health Inpatient - 60 days</td>
<td>1b</td>
<td>$2,599</td>
<td>$2,079</td>
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<tr>
<td>Mental Health Inpatient - 15 days</td>
<td>1b</td>
<td>$1,953</td>
<td>$1,562</td>
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<tr>
<td>Skilled Nursing Facility – First 20 Days</td>
<td>2a</td>
<td>$40/day</td>
<td>$0/day</td>
</tr>
<tr>
<td>Skilled Nursing Facility – Days 21 through 100</td>
<td>2a</td>
<td>$160.00/day</td>
<td>$160.00/day</td>
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<tr>
<td>Emergency Care/Post Stabilization Care</td>
<td>4a</td>
<td>$75</td>
<td>$75</td>
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<tr>
<td>Urgently Needed Services$^3$</td>
<td>4b</td>
<td>$65</td>
<td>$65</td>
</tr>
<tr>
<td>Partial Hospitalization</td>
<td>5</td>
<td>$55/day</td>
<td>$55/day</td>
</tr>
<tr>
<td>Home Health</td>
<td>6a</td>
<td>20% or $35</td>
<td>$0</td>
</tr>
<tr>
<td>Primary Care Physician</td>
<td>7a</td>
<td>$35</td>
<td>$35</td>
</tr>
<tr>
<td>Chiropractic Care</td>
<td>7b</td>
<td>$20</td>
<td>$20</td>
</tr>
<tr>
<td>Occupational Therapy</td>
<td>7c</td>
<td>$40</td>
<td>$40</td>
</tr>
<tr>
<td>Physician Specialist</td>
<td>7d</td>
<td>$50</td>
<td>$50</td>
</tr>
<tr>
<td>Psychiatric and Mental Health Specialty Services</td>
<td>7e and 7h</td>
<td>$40</td>
<td>$40</td>
</tr>
<tr>
<td>Physical Therapy and Speech-Language Pathology</td>
<td>7i</td>
<td>$40</td>
<td>$40</td>
</tr>
<tr>
<td>Therapeutic Radiological Services</td>
<td>8b</td>
<td>20% or $60</td>
<td>20% or $60</td>
</tr>
<tr>
<td>DME-Equipment</td>
<td>11a</td>
<td>N/A</td>
<td>20%</td>
</tr>
<tr>
<td>DME-Prosthetics</td>
<td>11b</td>
<td>N/A</td>
<td>20%</td>
</tr>
<tr>
<td>DME-Medical Supplies</td>
<td>11b</td>
<td>N/A</td>
<td>20%</td>
</tr>
<tr>
<td>DME-Diabetes Monitoring Supplies</td>
<td>11c</td>
<td>N/A</td>
<td>20% or $10</td>
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<td>DME-Diabetic Shoes or Inserts</td>
<td>11c</td>
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<tr>
<td>Renal Dialysis</td>
<td>12</td>
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<tr>
<td>Part B Drugs-Chemotherapy$^4$</td>
<td>15</td>
<td>20% or $75</td>
<td>20% or $75</td>
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<tr>
<td>Part B Drugs-Other</td>
<td>15</td>
<td>20% or $50</td>
<td>20% or $50</td>
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