Wakely
An HMA Company

Summary of Advance Notice of Methodological Changes

Calendar Year 2025

Medicare Advantage Capitation Rates and Part C and Part D Payment Policies

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Executive Summary

On January 31, 2024, CMS released the CY 2025 Advance Notice, which details planned changes to the Part C and Part D capitation and risk adjustment methodology for calendar year (CY) 2025. The comment period for the Advance Notice ends March 1, 2024, and the final rating provisions will be announced no later than April 1, 2024.

The CY 2025 fee-for-service (FFS) Growth Rate, which is the major driver of Part C benchmark rates, is estimated at 2.57%. The continued phase in removing Medicare Advantage (MA) related indirect medical education (IME) and direct graduate medical education (DGME) amounts results in a -0.96% impact on the growth rate. The implied total impact of the IME and DGME removal has become larger (i.e. a bigger decrease) as compared with the estimate from the CY 2024 Advance Notice.

CMS is maintaining the non-ESRD Part C risk model and phase-in blend schedule of the 2024 CMS-HCC and 2020 CMS-HCC models for CY 2025. CMS is proposing a different method to calculate the FFS normalization factors associated with these two models. The factors are 1.045 and 1.153 for the 2024 and 2020 models, respectively. Per the Advance Notice Fact Sheet published by CMS, the combined effect of the change in blended models and raw risk scores for 2025 Part C scores is -2.45% (i.e. risk scores will be reduced by an additional 2.45% as compared with CY 2024).

The proposed coding intensity adjustment factor remains at the statutory minimum of 5.9%.

Due to changes in the Part D Defined Standard benefit for CY 2025 resulting from the Inflation Reduction Act, CMS is proposing a revised 2025 RxHCC model. The new model is based on 2021 diagnoses and 2022 prescription drug expenditure data. No clinical update to the RxHCC definitions is proposed. In addition to the revised RxHCC model, CMS is also proposing to introduce separate RxHCC FFS normalization factors for non-PACE organizations. A normalization factor of 1.073 is proposed for MA-PD enrollees and 0.955 for PDP enrollees.

Following is a brief summary of the key changes and proposals in the Advance Notice.

Part C Growth Rates

The following table shows the estimated growth rates for 2025.

Table 1: Estimated 2025 Growth Rates

Growth Rate	Percentage
FFS – Non-ESRD	2.57%
MA Growth Percentage (including FFS and MA) – Non-ESRD	1.98%
Dialysis-only ESRD	3.12%

For the non-ESRD rates, CMS is continuing the phase in to remove the MA-related IME and DGME from the USPCC calculations. The impact of the continued phase in lowers the 2025 non-ESRD FFS USPCC and corresponding non-ESRD FFS growth percentage by 0.96 percent.

Part C Risk Scores

In the CY 2024 Advance Notice, CMS proposed to use a new Part C non-ESRD risk score model, to be known as the 2024 CMS-HCC model. In the March 31, 2023, Final Announcement, CMS announced that a blend of the existing 2020 CMS-HCC model and new 2024 CMS-HCC model would be used to calculated payment year (PY) 2024 scores. The blend of the two models was to be phased in over three years, as follows:

Table 2: Non-ESRD Part C Risk Score Model Phase-In Schedule

Year	2024 CMS-HCC v28	2020 CMS-HCC v24
2024	33%	67%
2025	67%	33%
2026	100%	0%

In the CY 2025 Advance Notice, CMS is proposing to continue the blending schedule in Table 2.

For CY 2025, CMS is proposing to use a multiple linear regression methodology to calculate FFS normalization factors for all CMS-HCC models. This is a change from past CMS practice. The stated goal of the new model is to properly capture the impact of the COVID pandemic on risk scores. The resulting FFS normalization factor for the 2024 CMS-HCC model is 1.045, which is a significant increase over the CY 2024 factor of 1.015. In the Advance Notice Fact Sheet[1], CMS estimates that 2025 over 2024 blended impact of the new normalization factors and risk model updates for non-PACE plans is -2.45% (i.e. CY 2025 normalized, blended risk scores will be 2.45% lower than CY 2024, all other factors equal).

[1] https://www.cms.gov/newsroom/fact-sheets/2025-medicare-advantage-and-part-d-advance-notice-fact-sheet

The CY 2024 coding pattern adjustment is set at the statutory minimum of 5.90%, which represents no change compared with CY 2022.

Part D Risk Scores

Due to the changes in projected plan liability associated with the revised CY 2025 Defined Standard Part D benefit, as required by the Inflation Reduction Act, CMS is proposing to recalibrate current RxHCC to account for these changes. The new model is recalibrated on 2021 diagnoses for 2022 expenditures. CMS is further proposing to use separate FFS normalization factors for MA-PD enrollees compared with PDP enrollees. The MA-PD factor is proposed to be 1.073, and the PDP factor is 0.955.

CMS is also proposing an alternative model recalibrated on 2018 diagnoses and 2019 expenditures and is seeking comment on the appropriateness of this alternative model compared with the proposed model.

For PACE organizations, CMS is proposing a new model reflecting an update of the clinical version of the RxHCC model, to be recalibrated on 2018 diagnoses and 2019 expenditures. The PACE RxHCC FFS normalization factor for CY 2025 is proposed to be 1.163.

EGWPs

Plans will not need to file EGWP bid pricing tools (BPTs) for CY 2025, as was the case in CY 2024.

CMS proposes to continue calculating separate HMO and PPO bid-to-benchmark ratios based on individual 2023 bids and then re-weighted with February 2023 EGWP enrollment. The preliminary 2024 bid-to-benchmark ratios compared to the 2023 rates are as follows:

Table 3: Estimated Bid-to-Benchmark Ratios

Applicable Percentage	2024 Ratios	2025 Estimates
0.95	78.5%	78.5%
1.00	77.2%	76.8%
1.075	76.7%	76.2%
1.15	76.9%	76.6%

TBC Threshold

CMS has not yet published requirements for MA and PD benefits related to the Total Beneficiary Cost (TBC) threshold.

Part D Defined Standard Benefit Changes

Significant changes to the Defined Standard Benefit resulting from the Inflation Reduction Act (IRA) of 2022[2] will apply for CY 2025. Unlike most other provisions in the Advance Notice, these changes are not proposed, but are final. The key IRA changes for 2025 are as follows:

- Elimination of the gap benefit phase.
- Reduction in the beneficiary out-of-pocket maximum to $2,000 for CY 2025 from $8,000 in CY 2024.
- Reconfiguration of the manufacturer coverage gap discount program (to be called "Manufacturer Discount Program"). The discount for applicable drugs will generally be 10% in the initial coverage phase and 20% in the catastrophic phase. A small number of manufacturers will pay lower discounts initially and then phase into the full amounts over several years. Unlike previous years, the discounts will apply to both low-income (LI) and non-low-income (NLI) beneficiaries. The coverage gap discount program applied only to NLI enrollees in past years.
- The base beneficiary premium growth will be held to no more than 6% of the CY 2024 level ($34.70 PMPM).

A separate document titled "Draft CY 2025 Part D Redesign Program Instructions" was released at the same time of the Advance Notice. It contains detailed descriptions of how the Defined Standard benefit design changes will be implemented in CY 2025.

Part D Parameters and Risk Sharing

The Inflation Reduction Act specifies the beneficiary out-of-pocket (OOP) maximum amount for CY 2025 ($2,000), so CMS did not need to estimate the OOP level as in past years. The defined standard deductible still requires CMS to estimate the level. The preliminary update to the Part D DS deductible for CY 2025 is $590. The annual percentage increases in average expenditures and the consumer price index were announced as 8.58%.

No changes are proposed to the risk sharing corridors.

[2] H.R.5376 - 117th Congress (2021-2022): Inflation Reduction Act of 2022 | Congress.gov | Library of Congress

Star Rating Changes

Various updates for the Star Rating measures are proposed. New measures concepts and methodological enhancements for future years are also introduced.

CMS proposed rules for CY 2025 for geographic areas impacted by “Extreme and Uncontrollable Circumstances”. In addition, the star rating weight on the all-cause readmissions measure is proposed to be 3, as compared with the current weight of 1.

For 2026 and subsequent years, several changes are proposed. In particular, the weight on Patients’ Experience and Complaints and Access measures is proposed to be reduced from 4 to 2.

Wakely Analysis - Wakely Estimated Impact of Growth Rates Combined with Payment Reform

Wakely estimates that, on a nationwide average basis, and as compared with 2024, nationwide average 2025 Part C benchmarks will:

- Increase by 2.32 % on a standardized (i.e. 1.00) risk score basis. This incorporates the FFS growth rate, changes in applicable percentage by county, average change in star ratings and quality bonus, the impact of benchmark cap and the proposed methodology change to IME and DGME cost removal. It does not include changes to the county level IME/DGME adjustment factors, VA and DoD adjustment factor, credibility factors or county rebasing and repricing.
- Decrease by -0.19% on a risk-adjusted basis. The risk-adjusted change incorporates the year-over-year impact of FFS normalization factors, MA Coding Pattern adjustment and the risk model revision (i.e. the continued phase-in of the 2024 CMS-HCC risk adjustment model).

The Wakely risk-adjusted estimate is based on the following components:

- Change in 1.00 benchmarks
- Impact of change in fee-for-service normalization factor
- Assumption of no trend in raw risk scores
- Average change in star ratings based on January 2024 enrollment

Table 4 shows our estimates of the components that make up this change:

Table 4: Change in Blended Risk-Adjusted Benchmarks 2024 to 2025

Component	2024 to 2025 Change
Growth Rate [2]	2.57%
Applicable %	-0.08%
Star Rating/Quality Bonus	0.03%
Benchmark Cap	-0.19%
Total Benchmark Change	**2.32%**
FFS Normalization & Risk Model Revision	-2.45%
MA Coding Pattern	0.00%
Total Risk Score Change	**-2.45%**
TOTAL	**-0.19%**
[1] Based on January 2024 MA enrollment and Fall 2023 Star Ratings	
[2] Includes -0.96% adjustment for the removal of MA-related IME and DGME costs	

Below is a brief definition of each of the elements in Table 4.

Growth Rate. This is the impact of the FFS (+2.57%) growth rate.

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 due to star rating changes between 2024 and 2025.

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 vary year-to-year as plans change star ratings, and as the MA trend differs from the FFS trend. Note, in years when the FFS growth rate is greater than the MA growth rate, the impact of the benchmark cap is more prevalent.

Part C Fee-for-Service (FFS) Normalization Factor and Risk Model Revision. The 2024 Part C FFS normalization was a 33%/67% blend of 1.015 (v28) and 1.146 (v24). For 2025, CMS is proposing to continue the phase-in of the v28 model and will blend the v28 and v24 models 67%/33%. The proposed FFS normalization factors for 2025 are 1.045 (v28) and 1.153 (v24). CMS is proposing a new methodology for calculating the underlying trends in the normalization factor by using a multiple regression model which considers the impact of COVID-19 for 2021 and subsequent years. Based on the Fact Sheet, CMS estimates the overall change to both the risk adjustment model and FFS normalization will be -2.45%. They also state the impact due to the risk adjustment model revision phase in is -4.41% and the impact due to the new FFS normalization factors is +1.99%.

Change in Coding Pattern Adjustment. The coding pattern adjustment for 2025 will be -5.90%, which is the minimum adjustment required by the Affordable Care Act. There will be no change from 2024.

Change in Bid and Rebate Amounts

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 both 2024 and 2025 bids are 77% of the benchmark, then we estimate the change in Part C payments from 2024 to 2025 to be a decrease of -0.33% (see Table 2).

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 change in risk-adjusted benchmarks to be -0.19%. If we include estimated changes in bid and rebate levels, then the impact to Part C revenue is -0.33%. This estimate is based on the following assumptions:

- Plans bid at 77% of the benchmark in 2025. This is based on the published bid-to-benchmark ratios in the 2025 Advance Notice.
- Annual risk score coding trend is 0% for a static population
- Nationwide average star ratings, which result in an average rebate percentage of 66.3% in 2024 and 65.7% for 2025
- No consideration for sequestration or insurer fee

Table 5 shows the calculations underlying our estimates.

Table 5: Estimated Change Risk-Adjusted Bid and Rebate 2024 to 2025

	2024	2025	2025/2024
1.0 MA Benchmark [1]	$1,147.33	$1,173.91	2.32%
Raw Risk Adjustment Factor [2]	1.0000	1.0000	0.00%
Risk Score Model Change	1.0000	0.9563	-4.37%
FFS Normalization & Risk Model Revision	1.1028	1.0810	2.01%
MA Coding Pattern Adjustment	0.9410	0.9410	0.00%
Total RAF Adjustments	0.8533	0.8324	-2.45%
Risk-Adjusted Benchmark	$979.03	$977.18	-0.19%
Assumed Risk-Adjusted Bid [4]	**$753.86**	**$752.43**	**-0.19%**
Savings (Benchmark less bid)	$225.18	$224.75	-0.19%
Rebate	**$149.27**	**$147.75**	**-1.02%**
Risk-Adjusted Bid + Rebate	**$903.12**	**$900.17**	**-0.33%**

[1] Based on nationwide average MA enrollment by county as of January 2024
[2] Assumed no trend in risk scores
[3] Bid set at 77% of risk-adjusted benchmark
[4] 66.3% for 2024 and 65.7% for 2025

Please note, CMS's stated positive impact due to the FFS normalization change is driven by a shift in the weighting on the v24 and v28 models. The FFS normalization factors for each model have increased from 2024 to 2025, as discussed above. However, because the weighting is shifting from 33%/67% (v28/v24) to 67%/33% the blended FFS normalization factor appears to be a positive change.

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 difference changes in FFS benchmarks by county.

Attachment I: Preliminary Estimates of the National Per Capita Growth Percentage and the National Medicare Fee-for-Service Growth Percentage for CY 2025

Section A. Data and Assumptions Supporting USPCC's.

Proposed Technical Update: CMS is proposing a continuation of the phase in of the technical update to remove additional Medical Education Payments in the Non-ESRD USPCC Baseline.

BACKGROUND

Section 1886(d)(11) of the Affordable Care Act (Act) directs the Secretary to provide inpatient prospective payment system hospitals with an additional payment amount for indirect medical education (IME) costs for discharges of Medicare Advantage (MA) enrollees, and section 1886(h)(3)(D) of the Act directs the Secretary to provide hospitals with an additional payment amount for direct graduate medical education (DGME) costs associated with services furnished to MA enrollees.

CMS states that prior non-ESRD United States per Capita Costs (USPCC) have included IME and DGME costs attributable to MA enrollees because the supporting data did not separately identify these payments from those made on behalf of FFS enrollees. CMS states that MA organizations (MAOs) had been effectively paid for these admission-related costs, even though CMS, and not MAOs, had been paying these costs associated with MA enrollees directly to hospitals.

In 2024, CMS is finalized a three-year phase in to remove the MA-related IME and DGME costs from the historical and projected non-ESRD USPCCs. In the 2024 rates, CMS applied one-third of the adjustment, estimating the impact to be -0.70% on the growth rate. For CY 2025, CMS is proposing to remove two-thirds of the adjustment and is estimating the incremental impact from 2024 to 2025 is -0.96%. These estimates imply that the impact of the adjustment has become more negative. The implied total change in growth rate (i.e. based on 100% implementation) from the 2024 estimate is -2.1%; whereas the total implied estimate based on the published incremental factor for 2025 is -2.9%.

SECTION B 2023 GROWTH PERCENTAGE ESTIMATES.

The preliminary estimate of the MA growth rate is +1.98% (last year the rate was +1.60%).

The non-ESRD fee-for-service growth rate is estimated at +2.57% (last year rate was +2.45%).

SECTION C USPCC ESTIMATES.

In the Notice, CMS noted that the estimates for the USPCCs includes consideration for the following:

COVID-19

- COVID-19 vaccine
- Utilization of services (presumably both deferred services and pent-up demand)
- Changes to MA coverage created by COVID-related legislation

- Cost sharing in excess of Medicare FFS cost sharing
- Specified testing-related services
- Prohibition on utilization management requirements related to COVID lab testing and testing-related services

PART B PROVISIONS OF THE IRA

- Part B manufacturer rebates
- Shifts in beneficiary coinsurance
- Exclusion of the Part B deductible for insulin furnished through durable medical equipment (DME)
- Cap of $35 beneficiary cost share for one month supply of insulin

CMS states the IRA adjustments related to the beneficiary cost share shifts are projected to increase Part B FFS expenditures and adjustments related to the Part B rebates are projected to have a negligible downward impact.

340B- ACQUIRED DRUG PAYMENT POLICY FOR CALENDAR YEARS 2018-2022

- CMS has included an adjustment for the Hospital Outpatient Prospective Payment System remedy for the 340B-Aquired Drug Payment Policy for Calendar Years 2018-2022 Final Rule. The adjustment causes upward restatements to the 2018-2022 USPCCs due to the $9B lump sum payment CMS will pay to affected providers.
- CMS has also included an adjustment to incorporate the future OPPS conversion factor change of -0.5% starting in 2026 (and continuing through 2041) to recover the budget neutrality adjustment from 2018-2022.
- The restatements in CMS's FFS USPCC estimates from the prior estimates in the CY 2024 Final Announcement are summarized in the Table 6.

Table 6: Restatement in Estimated FFS USPCC Costs

Year	Current/Prior
2026	-1.2%
2025	-1.4%
2024	-1.2%
2023	-0.1%
2022	1.5%
2021	1.4%
2020	1.2%
2019	1.0%
2018	1.0%

The positive restatements for 2018 to 2022 are driven by the $9B lump sum payment for 340-B drugs. In addition, a portion of the downward restatement for 2026 is driven by the -0.5% OPPS conversion factor change. It is unclear what is driving the negative restatement for 2025 and the remaining negative restatement for 2026.

As discussed in the Section “Wakely Estimated Impact of Growth Rates Combined with Payment Reform”, we estimate that the nationwide average change in blended standardized (non-risk adjusted) MA Benchmarks from 2024 to 2025 will be 2.32% and the nationwide average change in the blended risk adjusted benchmark will be -0.19%.

As has been the case in past years, the change in benchmarks can vary significantly depending on geographic area, plan star rating and applicable percentage. While CMS will not publish the final geographic relativities (aka Average Geographic Adjustment, or AGA, factors) until the Final Announcement, we can still estimate the impact of changing county quartiles, average star ratings, and a minor change in how CMS will develop the cost exclusions for kidney acquisition costs and direct graduate medical equipment.

Table 7 below shows the top five and bottom five growth rates by State (these changes include changes due to star rating, double bonus status, applicable percentage, benchmark cap, and kidney acquisition costs).

Table 7: Highest and Lowest Benchmark Changes by State

Rank	State	Change
1	HI	6.0%
2	ID	4.9%
3	CO	4.4%
4	DE	4.0%
5	FL	3.8%
46	WA	1.2%
47	MD	1.0%
48	CA	0.9%
49	OH	0.8%
50	RI	0.6%

SECTION D LOADING FOR CLAIMS PROCESSING COSTS.

Consistent with last year CMS is proposing to adjust the USPCC to include administrative costs incurred by the Medicare Administration Contractors (MAC's) as described in the ACA. The adjustments are consistent with those made in prior years.

Attachment II: Changes in the Payment Methodology for Medicare Advantage and PACE for CY 2025

Section A. MA Benchmark, Quality Bonus Payments, and Rebate

County benchmark rates, quality bonus payments, and rebates for CY 2025 are proposed to be calculated in a similar manner as in past years.

Some key items to note include the following:

- CMS intends to rebase county FFS rates in 2025, consistent with past practice.
- The Part C benchmark is capped at the "Applicable Amount" (aka pre-ACA), which is consistent with recent years; however, the total growth rate of 1.98% compared with the higher FFS growth rate of 2.57% means that more counties could be impacted by the cap. A higher star rating also increases the chance that the benchmark rates will be capped.

- As with past years, the double quality bonus percentages will apply for qualifying counites, but we will not know whether counties change double bonus status because CMS has not yet published the county re-basing which affects one of the three conditions needed to qualify.

Section B. Calculation of Fee for Service Cost

2025 FFS COUNTY COST

The FFS County cost for CY 2025 is calculated as the USPCC x AGA, where:

USPCC = the National Average FFS Cost, called the U.S. Per Capita Cost

AGA = County-level Geographic Index, called the Average Geographic Adjustment

- With the Advance Notice, CMS is releasing county-level 2022 FFS cost data used to develop 2025 rates:

  https://www.cms.gov/Medicare/Health-Plans/MedicareAdvtgSpecRateStats/FFS-Data

AGA DEVELOPMENT OVERVIEW:

- A five-year average of FFS costs from 2018 to 2022 is initially calculated (last year was 2017 to 2021) and is then adjusted.
- Costs for hospice and Cost plans are excluded.
- CMS will re-price 2018 to 2022 claims to the most current (i.e., FY2024) wage and geographic practice cost indices and adjust historical FFS claims for legislative changes.
  - This includes the repricing of the Medicare Durable Medical Equipment, Prosthetics, Orthotics, and Supplies (DMEPOS) claims in accordance with the payment rules in effect during the temporary gap period for the DMEPOS Competitive Bidding Program starting 1/1/2024.
  - The January 2024 fee schedules for repricing DMEPOS claims are accessible here: https://www.cms.gov/medicare/payment/fee-schedules/dmepos/dmepos-fee-schedule
  - Part B drugs will not be repriced, irrespective of the 340B remedy rule provision. (Many CY 2022 340B drug claims have been processed/reprocessed at the higher 340B payment rate already).

There are two additional adjustments included in the development of the AGAs:

Adjustments for Medicare Shared Savings Program and Innovation Center Models and Demonstrations, and Advanced Alternative Payment Models

The first adjustment incorporates shared savings and losses or episode savings and loses experienced under the Medicare Shared Savings Program and Innovation Center models and demonstrations into historical FFS experience. CMS is proposing to use more recent experience years to calculate this adjustment. A similar adjustment has been applied in prior years.

CMS is proposing a new adjustment related to Advanced Alternative Payment Models. Qualifying APM participants receive an incentive payment equal to 5% of their estimated aggregate payments for covered professional services furnished during the base year. Payments are made in the year after the base year, beginning in 2019. CMS is proposing to incorporate the APM incentive payments made in 2019 through 2022 into the historical ratebook experience.

Additional Adjustment to FFS per Capita Costs in Puerto Rico

An additional adjustment is being considered for Puerto Rico. Puerto Rico data only includes beneficiaries with Part A & B for all five years of the base period. (Puerto Ricans are not auto enrolled into Part B, they must opt in). CMS is considering whether to apply an adjustment to Puerto Rico FFS costs to reflect Puerto Rico's high proportion of zero-claimant members versus the national average. Such an adjustment has been applied in prior years.

After the AGA has been calculated, the following additional adjustments are made:

- GME and IME costs are removed.
- Counties with less than 1,000 members are blended with other counties in the market area for credibility.
- Adjustments are made for beneficiaries who are dually enrolled in Veteran Affairs and/or the Department of Defense health programs.
- Organ acquisition costs for kidney transplants.

Section C. Adjustments to the AGAs

SECTION C1. DIRECT GRADUATE MEDICAL EDUCATION

CMS is proposing to revise the data and methodology used to develop the DGME carveout for hospitals participating in the Maryland Total Cost of Care (TCOC) Model. The proposed adjustment will be based on the Provider Statistical & Reimbursement Report (PS&R) figures for MA admissions for each Maryland hospital with a graduate medical program for each calendar year.

The DGME carve-out factors for the 2025 rates will be published with the 2025 Rate Announcement.

SECTION C2. ORGAN ACQUISITION COSTS FOR KIDNEY TRANSPLANTS

Kidney acquisition costs (KAC), first removed in 2021, will continue to be carved out for non-PACE plans in 2025. Similar to the DGME exclusion, CMS changed the KAC calculation methodology in 2023 and will continue to use the new methodology in 2025, which once again uses the PSF as the source for carve-out percentage development. The 2025 KAC carve-out factors will be published with the 2025 Final Rate Announcement.

CMS also mentions considering the use of KAC data provided by the MAC to the Health Services Cost Review Commission to develop a KAC carve-out adjustment specifically for Maryland hospitals. This data is not available for the CY 2025 rate development.

SECTION C3. IME PHASE OUT

Indirect Medical Education costs are being phased out of MA capitation rates. For 2025, CMS will first calculate FFS rates including IME. The maximum reduction for any county in 2025 is 9.6% of the FFS rate. As in prior years, CMS will publish rates with and without the 2024 IME reduction.

Section D. MA ESRD Rates

ESRD Rates = [2018-2022 FFS ESRD dialysis USPCC] x [trend to 2025] x [State AGA] x [GME and IME removal factor] x [KAC removal factor].

- State AGA is the weighted average of state ESRD FFS dialysis costs for 2018 to 2022 divided by the national average for the same timeframe normalized for risk score.
- CMS intends to reprice historical inpatient, outpatient, SNF, and ESRD PPS claims for 2018 to 2022 to reflect the most recent wage indices (in this case FY2024) and reprice physician claims with the most recent Geographic Practice Cost Indices (CY 2024). This is a continuation of an enhancement introduced last year.
- ESRD state rates for PACE plans will include kidney acquisition costs.

CMS also continues to acknowledge MAO concerns regarding ESRD payment adequacy in light of the 21st Century Cures Act, which allows ESRD beneficiaries to enroll in MA plans. In the 2023 and 2024 Advance Notice, CMS provided details regarding an analysis of ESRD rates developed at a geographic level smaller than state. The analysis suggested potentially concerning impacts on specific geographic areas. In this years Advance Notice, they call out another analysis where they reviewed 2021 and 2022 experience as reported on Worksheet 1 of the ESRD BPT. For most

plans the revenue was adequate to cover the corresponding net medical expenses. Therefore, they do not plan to revise the methodology for CY 2025.

Section E. Location of Network Areas for PFFS Plans in Plan Year 2026

Non-employer MA PFFS plans offered in a network area must meet certain access standards. Network area is defined as an area that the Secretary identifies as having at least two network-based plans. CMS will publish the list of network areas for plan year 2026 with the CY 2025 Rate Announcement.

Section F. Employer Group Waiver Plans

For 2025, CMS intends to continue to waive bid pricing tool requirements for Employer Group Waiver Plans (EGWPs).

CMS is also proposing to continue to use the same methodology that was used for 2024 in establishing MA EGWP payment amounts, which is to use 2024 bid-to-benchmark ratios weighted by February 2024 enrollment.

For 2025, CMS has published preliminary bid-to-benchmark ratios for EGWPs. These preliminary ratios are not final and are based on January 2024 enrollment instead of the intended February 2024 enrollment.

Table 8: EGWP Bid to Benchmark Ratios

Applicable Percentage	Proposed 2025 Bid to Benchmark Ratio	2024 Bid to Benchmark Ratio	Change
0.95	78.5%	78.5%	0.0%
1.00	76.8%	77.2%	-0.4%
1.075	76.2%	76.7%	-0.5%
1.15	76.6%	76.9%	-0.3%

CMS will continue to allow MA EGWPs to use a portion of Part C payment to buy down enrollee Part B premium. CMS will continue to collect Part B premium buy-down amounts in the EGWP PBP submission. EGWPs that choose to use a portion of their payment to buy-down Part B premium will have that amount reduced from their capitated payment. The Part B buy-down amount cannot vary among beneficiaries within a plan and is subject to the same maximum Part B buy-down amount as non-EGWP plans.

Section G. CMS-HCC Risk Adjustment Model for CY 2025

CMS is continuing its three-year phase in of the 2024 CMS-HCC model with CY 2025 being the second year. CY 2025 risk scores will be calculated as a blend of 33 percent of risk scores calculated with the 2020 CMS-HCC model and 67 percent calculated with the 2024 CMS-HCC model.

MA Risk Score Trend: Using the MA risk scores from 2018 through 2020, CMS estimates that the average risk score trend for MA plans is 3.30 percent under the 2024 CMS-HCC model and 5.00 percent under the 2020 CMS-HCC model. The blended MA risk score trend (using the same blend as proposed for the CY 2025 risk scores) is 3.86 percent.

CMS-HCC Model for PACE Organizations: The 2017 CMS-HCC model will continue to be used to calculate the risk scores for PACE organization.

Section H. End Stage Renal Disease (ESRD) Risk Adjustment Models for CY 2025

In CY 2025, CMS will continue to use the updated 2023 ESRD risk adjustment models for dialysis, transplant, and post-graft beneficiaries. The 2019 ESRD risk adjustment models will continue to be used for PACE organizations.

Section I. Frailty Adjustment for PACE Organizations and FIDE SNPs

A continuation of the CY 2024 frailty factors is proposed for CY 2025. Consistent with the phase-in of the 2024 CMS-HCC Model, the frailty factors would be calculated as 33 percent of the frailty score calculated with the 2020 CMS HCC model frailty factors and 67 percent of the frailty score calculated with the 2024 CMS-HCC model frailty factors.

Changes for FIDS-SNPS in CY 2025: Beginning in CY 2025, enrollment in FIDE SNPs will be limited to full-benefit dually eligible individuals who are also enrolled in an affiliated Medicaid managed Care Organization (MCO). Frailty factors for non-dual and partial-benefit dually eligible individuals will not be applicable to beneficiaries enrolled in FIDE SNPs beginning in plan year 2025.

Frailty scores are calculated using the prior year survey responses meaning the 2025 frailty scores are calculated from the 2024 responses. Because the 2024 enrollment may include beneficiaries without full Medicaid benefits, for CY 2025 only full Medicaid frailty factors will be used to calculate FIDE SNP frailty scores regardless of the respondent's 2024 Medicaid status.

PACE Organizations: For PACE organizations, CMS proposed continuing to use the 2017 CMS-HCC model and the frailty factors associated with the 2017 CMS-HCC model to calculate the frailty scores for PACE organization in CY 2025. Table 9 shows the frailty factors.

Table 9: Frailty Factors Associated with the 2017 CMS-HCC Model - PACE Organizations

Activities of Daily Living (ADL)	Non-Medicaid	Medicaid
0	-0.083	-0.093
1-2	0.124	0.105
3-4	0.248	0.243
5-6	0.248	0.420

Section J. Medicare Advantage Coding Pattern Difference Adjustment

For CY 2025, CMS proposes to apply the statutory minimum MA coding pattern difference adjustment factor of 5.90 percent.

Section K. Normalization Factors

Since 2007, CMS has largely used the same linear slope methodology for calculating normalization factors. However, The FFS trends from 2021 to 2023 are higher than FFS risk score trends before the pandemic. For payment years CY 2023 and CY 2024, CMS continued long-standing normalization methodology with modifications to account for the effects of the pandemic on the trend.

For CY 2024, CMS used 2018 through 2022 FFS risk scores excluding the 2021 as the basis to calculate the 2024 CMS-HCC FFS normalization factor. For the 2020 CMS-HCC factor, CMS risk continued to use 2016 through 2020 FFS scores, as they did for CY 2023. The 2024 CMS-HCC model has a denominator year of 2020; whereas the denominator year is 2015 for the 2020 CMS-HCC model.

For CY 2025, CMS is proposing to use a multiple linear regression methodology to calculate all FFS normalization factors for CMS-HCC models, which incorporates historical FFS risk scores from the most current five years of average FFS risk scores (2019-2023) and includes a flag that identifies whether an average FFS risk score is based on dates of service before or after the onset of the COVID-19 pandemic. For the COVID-19 flag used to calculate the proposed CY 2025 normalization factors, CMS considered FFS risk scores prior to 2021 (dates of service before 2020) as the “pre-COVID-19” period, and FFS risk scores from 2021 onward (dates of service starting in 2020) as the “post-COVID-19” period.

Below is a description of the proposed multiple linear regression methodology for calculating CY 2025 normalization factors for the CMS-HCC models.

The multiple linear regression equation is: $Y = \beta_0 + \beta_1 x_1 + \beta_2 x_2$, where

Y = Predicted FFS risk score for a given year (i.e., Normalization Factor)

β_0 = Intercept

β_1 = Regression coefficient for the average annual change in FFS risk scores

x_1 = The specific year to be predicted

β_2 = Regression coefficient for the impact of the COVID-19 pandemic on FFS risk scores

x_2 = COVID-19 flag (0 for years before CY 2021, 1 for CY 2021 and onwards)

SECTION K1. NORMALIZATION FACTORS FOR THE PART C CMS-HCC MODELS

Table 10 shows the regression coefficients CMS used to calculate the proposed CY 2025 normalization factors for each of the three-Part C CMS-HCC risk adjustment models. The resulting normalization factors are also shown.

Table 10. Part C CMS-HCC Model Normalization Factor Regression Coefficients

	2024 CMS-HCC Model	2020 CMS-HCC Model	2017 CMS-HCC Model
Intercept (β0)	-36.1638	-50.2238	-49.8144
Average Change in FFS Risk Scores (β1)	0.0184	0.0254	0.0252
COVID-19 Flag (β2)	-0.0513	-0.0580	-0.0583
Proposed 2025 normalization factor	1.045	1.153	1.157

SECTION K2. NORMALIZATION FACTORS FOR THE ESRD DIALYSIS CMS-HCC MODELS

Table 11 shows the regression coefficients CMS used to calculate the proposed CY 2025 normalization factors for both ESRD Dialysis CMS-HCC models. The CY 2025 normalization factors are also shown.

Table 11. ESRD Dialysis Model Normalization Factor Regression Coefficients

Coefficient	2023 ESRD Dialysis Model	2019 ESRD Dialysis Model
Intercept (β0)	-22.4232	-26.4102
Average Change in FFS Risk Scores (β1)	0.0116	0.0136
COVID-19 Flag (β2)	-0.0233	-0.0267
Proposed 2025 normalization factor	1.044	1.103

SECTION K3. NORMALIZATION FACTORS FOR THE ESRD FUNCTIONING GRAFT CMS-HCC MODELS

Table 12 shows the regression coefficients CMS used to calculate the proposed CY 2025 normalization factors for both ESRD Functioning Graft CMS-HCC models. The 2025 normalization factors are also shown.

Table 12. ESRD Functioning Graft Model Normalization Factor Regression Coefficients

Coefficient	2023 ESRD Functioning Graft Model	2019 ESRD Functioning Graft Model
Intercept (β0)	-46.2508	-49.8104
Average Change in FFS Risk Scores (β1)	0.0234	0.0252
COVID-19 Flag (β2)	-0.0603	-0.0607
Proposed 2025 normalization factor	1.074	1.159

Section L. Sources of Diagnoses for Risk Score Calculation for CY 2025

For non-PACE organizations, for CY 2025, CMS proposes to continue the policy adopted in the CY 2023 Rate Announcement to calculate risk scores for payment to MA organizations and certain demonstrations using only risk adjustment-eligible diagnoses from encounter data and FFS claims.

For PACE organizations, for CY 2025, CMS proposes to continue using the same method of calculating risk scores under the CMS-HCC and ESRD models used since CY 2015, which is to pool risk adjustment-eligible diagnoses from the following sources to calculate a single risk score (with no weighting): (1) encounter data, (2) Risk Adjustment Processing System (RAPS) data, and (3) FFS claims.

Attachment III: Benefit Parameters for the Defined Standard Benefit and Changes in the Payment Methodology for Medicare Part D for CY 2025

Section A. Annual Adjustments to Medicare Part D Benefit Parameters in 2025

SECTION A1. UPDATING THE MEDICARE PART D BENEFIT PARAMETERS

Beginning in CY 2025, the IRA eliminates the coverage gap phase and sets the annual OOP threshold at $2,000.

Given these changes, defined standard Part D prescription drug coverage in CY 2025 will consist of a three-phase benefit as follows:

- Annual deductible - Updated using the annual percentage increase (API) for 2025.
- Initial coverage phase – Because the coverage gap phase is eliminated, this phase now extends to the maximum annual OOP threshold.
- Catastrophic coverage phase - Beneficiaries will continue to pay no cost sharing for covered Part D drugs in the catastrophic coverage phase, consistent with CY 2024.

While the annual OOP threshold is set at $2,000 by statute for CY 2025, it will be updated using the API starting in CY 2026.

For CY 2025, the API applied to the applicable CMS Defined Standard Part D parameters is 8.58%, reflecting a 5.46% increase in the CY 2024 annual percentage trend and a multiplicative adjustment of 2.96% for prior year revisions.

CY 2025 Part D Defined Standard benefit changes are shown below and are summarized in Table 13.

- $590 deductible ($545 in 2024)
- $2,000 OOP ($8,000 in 2024)
- $1.60/$4.90 copays for full subsidy full benefit duals ($1.55/$4.50 in 2024)

Table 13: CY 2025 Part D Benefit Parameters for the Defined Standard Benefit

Standard Benefit	2024	2025
Deductible	$545	$590
Initial Coverage Limit	$5,030	Not Applicable
Out-of-Pocket Threshold	$8,000	$2,000
Full Subsidy-Full Benefit Dual Eligible (FBDE) Individuals		
Deductible	$0.00	$0.00
Copayments for Institutionalized Beneficiaries [category code 3]	$0.00	$0.00
Copayments for Beneficiaries Receiving Home and Community-Based Services [category code 3]	$0.00	$0.00
Maximum Copayments for Non-Institutionalized Beneficiaries		
Up to or at 100% FPL [category code 2]		
Up to Out-of-Pocket Threshold		
Generic/Preferred Multi-Source Drug	$1.55	$1.60
Other	$4.60	$4.80
Between 100% and 150% FPL [category code 1]		
Up to Out-of-Pocket Threshold		
Generic/Preferred Multi-Source Drug	$4.50	$4.90
Other	$11.20	$12.15
Full Subsidy-Non-FBDE Individuals		
Applied or eligible for QMB/SLMB/QI or SSI and income at or below 150% FPL and resources ≤ $15,720 (individuals) or ≤ $31,360 (couples) [category code 1]		
Deductible	$0.00	$0.00
Maximum Copayments up to Out-of-Pocket Threshold		
Generic/Preferred Multi-Source Drug	$4.50	$4.90
Other	$11.20	$12.15
Retiree Drug Subsidy Amounts		
Cost Threshold	$545	$590
Cost Limit	$11,200	$12,150

SECTION A2. CALCULATION METHODOLOGIES FOR THE ANNUAL PERCENTAGE INCREASE (API) AND CONSUMER PRICE INDEX (CPI)

For the CY 2025 benefit parameters, CMS used Part D program data to calculate the annual percentage trend of 5.46% by comparing the ratio of the average per capita cost for August 2023 – July 2024 (use PDE through December 2023 projected through July 2024) and the average per

capita cost for August 2022 – July 2023. An adjustment of 2.96% is applied to reflect the impact of prior year revisions, for a total annual percentage increase for 2025 of 8.58%.

The annual percentage increase in CPI for September 2025 is the combination of the projected trend for September 2024 (2.61%) and a multiplicative prior year revision of -0.11% for a total annual percentage increase of 2.50%.

SECTION A3. ANNUAL ADJUSTMENTS FOR PART D BENEFIT PARAMETERS IN CY 2025

See Table 13 above for the annual benefit parameters. The initial coverage limit is no longer applicable, and the out-of-pocket threshold amount was set by statute. The deductible was derived by multiplying the CY 2024 deductible by the CY 2025 API and rounding.

Section B. Sunset of the Coverage Gap Discount Program and Establishment of the Manufacturer Discount Program

The Coverage Gap Discount Program (CGDP) sunsets effective January 1, 2025, and will be replaced by the new Medicare Part D Manufacturer Discount Program (the “Discount Program”).

Under the new Discount Program, the manufacturer will typically pay a 10 percent discount for applicable drugs in the initial coverage phase. In the catastrophic phase, manufacturers will typically pay a 20 percent discount for applicable drugs. For CY 2025, manufacturers eligible for the “specified manufacturer” and “specified small manufacturer” phase-ins will pay a 1 percent discount in the initial coverage and catastrophic coverage phases for certain applicable drugs dispensed to certain beneficiaries.

Section C. Part D Premium Stabilization

As enacted by the IRA, the Base Beneficiary Premium (BBP) for CY 2025 will not be greater than CY 2024 BBP, which was $34.70 (as released in the July 31, 2023, HPMS memorandum), increased by 6%, or $36.78.

Consistent with CY 2024, the direct subsidy amount will change depending on the impact of premium stabilization on the BBP calculation and, thereby, a plan’s basic Part D beneficiary premium. As a result, the portion of the plan’s bid for basic Part D coverage not funded by basic Part D premiums will continue to be paid through the direct subsidy.

Section D. Part D Calendar Year EGWP Prospective Reinsurance Amount

The methodology used to calculate the prospective reinsurance payments to all Part D Calendar Year EGWP sponsors needs to be updated with the CY 2025 Part D Redesign Program.

As noted in the Draft CY 2025 Part D Redesign Program Instructions, CMS plans to announce the CY 2025 prospective reinsurance payment amount for Part D Calendar Year EGWPs with the annual release of the Part D National Average Bid Amount (NAMBA), Part D BPP, and related Part D bid information in the summer of 2024.

Section E. Part D Risk Sharing

There are no changes to the Part D risk corridor calculations for CY 2025.

Section F. Retiree Drug Subsidy Amounts

See the Part D Benefit Parameters table (Table 13) for a comparison of the cost threshold and cost limit between CY 2024 and CY 2025.

Section G. RxHCC Model Risk Adjustment Model

The IRA has made substantial changes to the Part D benefit for 2025 and gross plan liability is expected to increase as a result. In addition, some ESRD oral drugs will be covered by Part B in 2025 and were removed from the model. CMS recalibrated the RxHCC model to account for these changes and improve the model's accuracy under the 2025 Part D benefit. CMS is proposing two calibration methodologies for the CY 2025 RxHCC model:

- An updated model that uses 2021 Medicare Fee-For-Service (FFS) and MA encounter data for diagnostic data, and 2022 Prescription Drug Event (PDE) data for expenditures. The denominator year is 2022.
- An updated model that continues to use 2018 Medicare Fee-For-Service (FFS) and MA encounter data for diagnostic data, and 2019 Prescription Drug Event (PDE) data for expenditures. This is the same calibration used by the current CY 2023 RxHCC model. The denominator year is 2020.

CMS is soliciting comments from stakeholders as to the value of either option considering the effects of COVID-19 on 2021 diagnoses and 2022 expenditures.

PACE ORGANIZATIONS

CMS is proposing to update the RxHCC risk adjustment model used to pay PACE organizations to the most recent clinical version, aligning the clinical version used for PACE with non-PACE, and calibrate the model to account for the IRA benefit changes using 2018 diagnoses and 2019 expenditures. Because RAPS data is still the primary source of diagnoses for PACE organizations, CMS is proposing the 2018/2019 calibration period as it represents the most recent data years that still has MA-PDs submitting RAPS data while also avoiding using data that is most affected

by the COVID-19 pandemic. The clinical revision will match the RxHCCs used in the non-PACE model which will use RxHCCs based on ICD-10 diagnoses rather than the ICD-9 codes currently used. The denominator year is 2020.

CHANGES IN AGE CATEGORY MODEL CONSTRAINTS

Because of the IRA benefit changes, more plan liability is sourced from high-cost RxHCCs, lowering the coefficients for age categories. A higher number of age category coefficients are negative under the new benefit design versus prior RxHCC models. In prior RxHCC models, these age categories were set to a coefficient of 0. With the increase in the amount of age categories that would be 0, CMS is proposing to revise their methodology for both PACE and non-PACE versions of the RxHCC model that will set negative coefficient age categories equal to other age categories that have positive coefficients, such that the resulting coefficient represents an enrollment-weighted average of the negative and positive coefficients.

PREDICTIVE RATIOS

Both the 2018/2019 and 2021/2022 calibration models result in underpredicting of actual plan expenditures for the lowest decile of predicted risk, overpredicting for the second through fourth deciles, and predictions close to actual expenditures for higher deciles. CMS comments that since the higher deciles reflect the highest risk in terms of expected spending, the prevalence of predictive ratios between 0.90 and 1.10 for these deciles reflect a model that predicts cost well for beneficiaries with higher predicted costs.

Section H. Normalization Factors for the RxHCC Models

CMS is proposing to apply separate normalization factors for MA-PD plans vs PDPs due to the significant change in the plan liability under the IRA and a trend of growing divergence between PDP and MA-PD risk scores. Between 2016 and 2022, the average MA-PD plan risk score calculated with the proposed 2025 RxHCC model increased 17.2 percent while the average PDP risk score calculated with the same model decreased 6.6 percent. In 2022, using the proposed RxHCC model, the average MA-PD plan risk score was 18.5 percent higher than the average PDP risk score. CMS finds that MA-PD plan costs tend to be overpredicted, while PDP costs tend to be underpredicted. This differential puts upward pressure on standardized bids for PDPs and, as a result, creates an unlevel playing field that generally inhibits fair competition between MA-PD plans and PDPs.

Because the RxHCC model normalization factors are based on both MA and FFS risk scores, CMS does not yet have final risk scores for 2023, as is the case for the Part C HCC model. Thus, CMS is not proposing a change in trend methodology to the multiple linear regression approach and is proposing to continue the use of the five-year linear trend methodology. CMS proposes to exclude 2021 risk scores from the trend calculation due to the impact of the COVID-19 pandemic.

Proposed 2021/2022 Calibration Model Normalization Factors:

- MA-PDs: 1.073
- PDPs: 0.955

Proposed 2018/2019 Calibration Model Normalization Factors:

- MA-PDs: 1.131
- PDPs: 0.932

Proposed PACE Model Normalization Factor: 1.163

Section I. Source of Diagnoses for Part D Risk Score Calculations for CY 2025

For non-PACE organizations, for CY 2025, CMS will continue to calculate Part D risk scores using only risk adjustment-eligible diagnoses from encounter data and FFS claims.

For PACE organizations, for CY 2025, CMS will continue to pool risk adjustment-eligible diagnoses from the following sources to calculate a single risk score (with no weighting): (1) encounter data, (2) RAPS data, and (3) FFS claims.

Attachment IV: Updates for Part C and D Star Ratings

Extreme and Uncontrollable Circumstances for 2025 Star Ratings

- For plans that qualify for disaster adjustments, the adjustment will result in the higher of their raw/unadjusted measure-level rating from 2024 (2022 performance) and 2025 (2023 performance).
- Several counties in Mississippi received EUC status (severe storms, straight-line winds, and tornadoes).
- Guam received EUC status (Typhoon Mawar).
- Maui County, Hawaii received EUC status (wildfires).
- Several counties in Florida and Georgia received EUC Status (Hurricane Idalia).

Changes to Existing Measures for 2025 Star Ratings

- Plan All-Cause Readmissions – Weight increased from 1 to 3.

Changes to Existing Star Rating Measures for Future Years (2026 and later)

- CMS is continuing to align a "Universal Foundation" of quality measures across all Quality and Value-Based Care Strategy programs to support high quality care and serve as a standard for the health care system. Pending future rulemaking, all Universal Foundation measures are expected to become a part of the Part C and D Star Ratings. Of the Universal measures not currently in the Star Rating program, one is submitted to be added (Initiation and Engagement of Substance Use Disorder Treatment (Part C)) and three are on the 2026 display page (Social Need Screening and Intervention (Part C)), Depression Screening and Follow-Up for Adolescents and Adults (Part C) and Adult Immunization Status (Part C).
- The weight of Patients' Experience and Complaints and Access measures will be reduced from 4 to 2 in 2026 Star Ratings (MY2024).
- Breast Cancer Screening (Part C) – NCQA is considering expanding the age range from 50-74 to 40-74 in measurement year 2024. If implemented, CMS intends to keep the legacy measure in the Star Ratings while the new measure is on the display page for two or more years (2026 Star rating at the earliest).
- Care for Older Adults – Pain Assessment (Part C) – NCQA is retiring this measure in the 2025 measurement year at the earliest. CMS will remove this measure right after (2027 Star Ratings). This removal no longer needs a rulemaking.
- Plan Makes Timely Decisions about Appeals and Reviewing Appeals Decisions (Part C) – CMS is considering updating these measures' deadlines for timely submission and submission timestamps to better align with electronic submission, which now makes up over 99 percent of case files. No timeline was specified.
- Care Coordination (Part C) – CMS is considering updating the questions for this measure, derived from the CAHPS survey. The new composite measure favorably field-tested in 2022. No timeline was specified.
- The following measures have non-substantive changes in 2026 Star Ratings and later:
    - Medication Adherence for Diabetes Medications / Medication Adherence for Hypertension (RAS Antagonists) / Medication Adherence for Cholesterol (Statins) / Statin Use in Persons with Diabetes / Medication Therapy Management Program Completion Rate for CMR (Part D) in measurement year 2024 (2026 Star Rating).
    - Members Choosing to Leave the Plan (Part C and D) (2026 Star Ratings).
    - Getting Appointments and Care Quickly in measurement year 2025 (2027 Star Rating)

  - Diabetes Care – Eye Exam (Part C) in measurement year 2025 (2027 Star Rating)
  - Statin Use for Patients with Cardiovascular Disease (Part C) in measurement year 2025 (2027 Star Rating)

- The following measures may be added to the Star Ratings program through future rulemaking:
  - Initiation and Engagement of Substance Use Disorder Treatment (Part C)
  - Initial Opioid Prescribing for Long Duration (Part D)
- CMS will provide more information on the NCQA plans to update the HEDIS specifications across multiple current and future measures with a goal to simplify the measurements and ensure gender inclusivity aligned with measure intent and clinical evidence:
  - Cross-Cutting: Identifying Chronic Conditions in HEDIS Measures (Part C)
  - Cross-Cutting: Gender-Affirming Quality Measurement in HEDIS (Part C)

Potential New Measure Concepts and Methodological Enhancements for Future Years

CMS is considering the following new measure concepts and methodological enhancements to the Star Rating program and is requesting feedback.

- Health Outcomes Survey (Part C) – CMS is exploring simplified, refined, and enhanced methodology for cross-sectional longitudinal studies that would also address health equity.
- Medicare Plan Finder Drug Pricing Measure (Part D) – CMS is developing new price comparison measure to provide transparency and highlight any unsavory health plans tactics to display artificially high and low pricing on the MPF during AEP. This measure may be added to the Star rating program as a companion to the MPF Price Accuracy measure.
- NCQA is developing or evaluating new measures and concepts that will leverage standardized electronic clinical data and other digital quality measurement capabilities with focus on measuring outcomes. The new measures will be developed as Electronic Clinical Data Systems (ECDS) measures. CMS intends to add many of these measures to the Star rating programs.
  - Blood Pressure Control for Patients with Hypertension (Part C) explored for measurement year 2025 and beyond. It may replace the existing Controlling Blood Pressure Star measure.
  - Breast Cancer Screening Follow-Up is in development for measurement year 2025.

- Social Connection Screening and Intervention (Part C) is in development for measurement year 2025. CMS may be adding this new measure to the MA Star Rating program through future rulemaking.
- Chronic Pain Assessment and Follow-Up (Part C). This new 2025 measure is intended to replace the current SNP Care for Older Adults - Pain Assessment indicator planned for retirement and would expand beyond the Special Needs population.
- Tobacco Use Screening and Cessation and Lung Cancer Screening and Follow-Up (Part C) are underdevelopment and targeted for release in 2026. CMS is considering adding them to the MA Star Rating program through future rulemaking.
- Functional Status Assessment Follow-Up (Part C) is planned for implementation in measurement year 2026 at the earliest.

Attachment V: Economic Information for the CY 2025 Advance Notice

Attachment V outlines the economic information relevant to significant provisions in the Advance Notice. Any provision that is not mentioned below is assumed to follow CY 2024 guidelines and, therefore, have no resulting impact.

Section A – Changes in Payment Methodology for Medicare Advantage and PACE for CY 2025.

- A1. Medicare Advantage and PACE non-ESRD Ratebook.
  - Growth rate for 2025 FFS non-ESRD rates estimate: 2.57%.
  - Growth rate for 2025 MA non-ESRD rates estimate: 1.98%.
  - Effective growth rate for 2025 MA non-ESRD rates estimate: 2.44%.
    - Net Impact $9.2 billion cost to Medicare Trust Funds.
  - MA growth percentage used to calculate the 2025 PACE non-ESRD is estimated to be 1.98%.
    - Net Impact $40 million cost to Medicare Trust Funds.
  - If CMS continues the adjustment to the calculation of county benchmarks in Puerto Rico for the number of beneficiaries with zero claims.
    - Net impact $260 million cost to Medicare Trust Funds.

- A2. Medicare Advantage and PACE non-ESRD Ratebook.
    - FFS growth percentage for the 2025 MA ESRD rates is estimated to be 3.12%.
        - Net impact $730 million cost to Medicare Trust Funds.
- A3. CMS-HCC Risk Adjustment Model
    - CMS is proposing the CY 2025 risk scores for none-PACE Part C organizations be calculated with a blend of 33 percent and 67 percent to the 2020 and 2024 CMS-HCC models, respectively.
        - Anticipated impact on MA risk scores: -2.45% relative to the blend in CY 2024
        - Represents $9.2 billion net savings to the Medicare Trust Fund in 2025.
        - Since the 2020 and 2024 models have different numbers of years their denominators, the two models are not comparable when determining the effect of the number of years on the risk score trend.
        - Each model (2020 and 2024) was appropriately normalized to remove the impact of FFS risk score trend.
- A4. ESRD Risk Adjustment.
    - No economic impact
- A5. Frailty Adjustment for FIDE SNPs
    - CMS is proposing the CY 2025 frailty scores for FIDE SNPs be calculated with a blend of 33 percent and 67 percent to the 2020 and 2024 CMS-HCC model frailty factors, respectively.
        - The resulting change in frailty score is 1.9%
        - Represents a net cost of less than $10 million to the Medicare Trust Funds in 2025
- A6. MA Coding Pattern Difference Adjustment
    - No year-over-year impact.
- A7. Part C Normalization
    - The impact of Normalization is zero

Section B – Changes in the Payment Methodology for Medicare Part D for CY 2025

- B1. Annual Percentage Increase for Part D Parameters
    - Generally unchanged from CY 2024
    - At current time, the lowering of the OOP threshold to $2000 and the shift to a three-phase benefit structure's impacts on the Medicare Trust Fund are uncertain.
        - The impacts of these parameters are dependent on plan bid assumptions.
- B2. Part D Risk Adjustment Model
    - CMS is proposing a new updated RxHCC risk adjustment model to reflect statutory changes in Part D.
    - CMS is proposing a model calibrated on 2021 diagnoses and 2022 expenditures for non-PACE organizations and a model calibrated on 2018 diagnoses and 2019 expenditures for PACE organizations.
        - This is reflected in Attachment III
    - The denominator is the average predicted per capita expenditure predicted by the payment model for a given year.
        - The denominator was obtained from MA-PD and PDP diagnosis data to create an average risk score of 1.0 for the Part D population in the denominator year.
    - Recalibration can result in changes in risk scores on the plan and individual level.
        - The average risk score in the denominator year remains 1.0.
        - Due to the average risk score being 1.0 in the existing and recalibrated model, the impact of recalibration is zero.
- B3. Normalization
    - CMS aims to offset the trend in risk scores and maintain a 1.0 average risk score across the Part D program (MA-PD plans and PDPs) for the RxHCC models.
    - The impact of normalization is $0.

Attachment VI: RxHCC Risk Adjustment Factors and Predictive Ratio Tables

The demographic component of continuing enrollee risk scores is drastically reduced for most age cohorts in the proposed CY 2025 RxHCC model as compared to the CY 2023 RxHCC model. The RxHCC coefficients are drastically increased for most RxHCCs in the proposed CY 2025 RxHCC model as compared to the CY 2023 RxHCC model. New enrollee coefficients are lower for non-low-income beneficiaries in the CY 2025 model as compared to the CY 2023 model, while for low-income beneficiaries they are higher in the CY 2025 model.