Wakely
An HMA Company

Summary of CY2025 Final Rate Announcement

Calendar Year 2025

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

April 12, 2024

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Executive Summary

On April 1, 2024, CMS released the CY2025 Medicare Advantage (MA) Capitation Rates and Part C and Part D Payment Policies (Final Announcement), which finalizes various proposals from the January 31, 2024, Advance Notice.

In general, most policies proposed in the Advance Notice will be adopted without change. Notably, all risk adjustment models and the related FFS normalization factors are not changing from the Advance Notice proposals.

The key changes from the Advance notice include changes to the non-ESRD growth rate and a minor decrease in the phase-in percentage for the IME/DGME reductions applied to Part C benchmark rates:

- The CY2025 fee-for-service (FFS) growth rate is calculated at 2.33%, which is 24 basis points lower than the proposed rate in the Advance Notice. The increase reflects both restatements of the trend as well as a 3-year phase-in of the IME/DGME adjustment.
- The CY2025 Total FFS USPCC Growth Percentage (Also called the National Per Capital Growth Percentage or NPCMAGP) is finalized at 2.31% (34 basis points higher than the 1.98% in the Advance notice). This percentage drives the pre-ACA benchmark, which caps the calculation of the benchmark. The higher total growth rate caused fewer benchmarks to be capped, particularly for rates that include a quality bonus payment increase.
- The technical update removing MA-related indirect medical education and direct graduate medical education costs projected costs will continue to be phased in; however, the phase-in percentage for 2025 will be 52%. The original phase-in percentage proposed for 2025 was 67%, so the lower phase-in has a nominal upward impact on the 2025 FFS growth rate.

Part C Growth Rates

The non-ESRD FFS growth rate percentage for CY2025 is 2.33%. The Total UPSCC non-ESRD growth rate percentage is 2.31%. The FFS growth rate decreased by 12 basis points and the Total rate increased by 71 basis points as compared with the CY2024 final growth rates.

The FFS Dialysis-only ESRD USPCC growth rate is 1.76% (down 51 basis points from last year).

County-specific rates were updated as usual for changes to the average geographic adjustment (AGA) calculations, which Wakely estimates to imply a nationwide average benchmark change of +0.20%. Note that CMS estimates this change to be +0.07%. The county level charges can be significant, due to the continued phase-in of the 2024 CMS-HCC Part C risk adjustment model

(aka v28) introduced in 2024 with a phase-in percentage of 33% and continuing in 2025 with a phase-in percentage of 67%.

Risk Scores and FFS Normalization

The CMS-HCC model used for CY2025 non-PACE non-ESRD will be a 33%/67% blend of the 2020 model (v24) and the 2024 model (v28), which is calibrated on ICD-10 diagnoses and reflects clinically based adjustments aimed at reducing excess payments to MA plans. FFS Normalization factors and the multiple regression model underlying their calculation remain unchanged from the Advance Notice. The factors will be 1.153 and 1.045 for the 2020 and 2024 models, respectively.

The coding pattern adjustment is set at the statutory minimum of 5.90%, which represents no change compared with CY2024.

No changes will be made to the Part C risk models used for payment in CY2025 for ESRD and PACE populations. FFS normalization factors will be calculated using the same multiple regression model proposed in the Advance Notice.

The RxHCC models for 2025 will use the following:

- For non-PACE organizations, the model proposed in the 2025 Advance Notice using 2021 diagnoses to predict 2022 payments. This was called the “Proposed” model in the Advance Notice.
- For PACE organizations, the model proposed in the 2025 Advance Notice using 2018 diagnoses to predict 2019 payments. This was called the “Alternative” model in the Advance Notice.

CMS is finalizing the use of separate RxHCC FFS normalization factors for Part D Prescription Drug Plans (PDPs) and Medicare Advantage Prescription Drug (MA-PD) plans in 2025. The factors will be 0.955 for PDPs and 1.073 for MA-PDs. The PACE RxHCC RxHCC FFS normalization factor will be 1.163 for 2025, as proposed.

EGWPs

CMS finalized the EGWP Bid-to-Benchmark Ratios as proposed in the Advance Notice.

Star Rating Changes

Various updates for the Star Rating measures are finalized. New areas related to “Extreme and Uncontrollable Circumstances” adjustments in 2022 and 2023 include Mississippi, Guam, Hawaii, Florida, and Georgia related to wildfires, severe storms, hurricanes, and a Typhoon.

The plan all-cause readmissions weight increased from 1 to 3.

CMS described new measure concepts being explored, including simplified longitudinal studies addressing health equity and a new price comparison measure in the Drug Pricing component of Medicare Plan Finder.

Medicare Part D - IRA

The changes from the Inflation Reduction Act to the Part D drug benefit will be implemented as described in the Advance Notice. The changes for CY 2025 include:

- Elimination of the coverage gap benefit phase.
- Elimination of the coverage gap discount program and introduction of the manufacturer discount program.
- A true out-of-pocket amount of $2,000.
- Significantly increased plan liability in the catastrophic benefit phase.
- Base beneficiary premium (BBP) growth will be held to no more than 6 percent by statute. The BBP for Part D in 2024 will be the lesser of the BBP for 2023 increased by 6 percent or the amount that would otherwise apply under the original methodology if the IRA were not enacted.

Overall MA Payment Impact

Wakely estimates that, on average, 2025 Part C standardized benchmarks will increase 2.38% over 2024 nationwide. This reflects the impact of the growth rate, change in star ratings and changes to applicable percentages (i.e., quartile rankings). We also estimate that the change in MA plan payment revenue for 2025 versus 2024 is expected to be –0.12%. This takes into account changes in Part C risk score adjustments, including the FFS normalization factor, the MA Coding Pattern adjustment, and an assumption of no trend in plan risk scores.

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 analysis of county specific benchmarks and plan revenue was aggregated using March 2024 CMS published MA enrollment and star ratings for payment year 2025.

Details regarding our calculations and assumptions are provided in the Wakely Analysis in the follow section this summary.

The remainder of this summary includes many details discussed at length in the Notice.

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 2.38% on a standardized (i.e., 1.00) risk score basis. This incorporates changes driven by FFS growth rate, rebasing/re-pricing, GME, KAC, VA DoD, IME, credibility, applicable percentage by county, average change in star ratings and quality bonus, and the impact of benchmark.
- Decrease by -0.12% on a risk-adjusted basis. The risk-adjusted increase incorporates the year-over-year impact of FFS normalization factors, MA Coding Pattern adjustment and the risk model revision. It does not include MA risk score coding trend.

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 and change in blend percentage for the two CMS-HCC risk adjustment models (i.e. v24 and v28).
- Assumption of no trend in raw risk scores.
- Average change in star ratings based on March 2024 enrollment

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

Table 1 – Change in Blended Risk-Adjusted Benchmarks [1]

	2024 to 2025
Growth Rate	2.28%
Rebasing/Re-pricing	0.20%
Applicable %	-0.08%
Star Rating/Quality Bonus	0.03%
Benchmark Cap	-0.04%
Total Benchmark Change	**2.38%**
FFS Normalization and Risk Model Revision	-2.45%
MA Coding Pattern	0.00%
Total Risk Score Change	**-2.45%**
TOTAL	**-0.12%**
[1] Based on March 2024 MA enrollment and Fall 2023 Star Ratings	

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

Growth Rate. This is the impact of the FFS (+2.28%) growth rate and the following adjustment factors:

- *Direct Graduate Medical Education (GME).* CMS is required to remove costs directly related to graduate medical educate. The change to this adjustment from 2024 to 2025 had minimal impact (-0.04%). Note, this adjustment is attributable to FFS beneficiaries only. The adjustment for MA beneficiaries is made to the USPCC before the county level rates are calculated.

- *Veteran's Affairs and Department of Defense (VA and DoD).* The change in these carve out factors from 2024 to 2025 had a minimal impact (0.04%).

- *Credibility.* As FFS enrollment decreases, credibility adjustments are necessary when developing the rates used for MA payment. We anticipate more counties will require a credibility adjustment in future years. The change from 2024 to 2025 was immaterial (0.00%).

- *Kidney Acquisition Costs (KAC).* Due to the 21st Century Cures Act, CMS is required to remove kidney acquisition costs from the development of the MA payment rates. The change from 2024 to 2025 was immaterial (-0.02%).

- *Indirect Medical Education (IME).* Costs attributable to indirect medical education are also removed from the payment rates. The change from 2024 to 2025 was immaterial (-0.04%). Note, this adjustment is attributable to FFS beneficiaries only. The adjustment for MA beneficiaries is made to the USPCC before the county level rates are calculated.

Rebasing/Re-pricing. The Average Geographic Adjustment (AGA) factors are derived via the compilation of five years of historical Medicare Parts A&B claim costs at the county level. For payment year 2025, historical claims from 2018 to 2022 are repriced to reflect the most current wage indices (Fiscal year 2024). Wakely calculated the overall impact to MA plans is 0.20%. The impact of the rebasing and re-pricing for 2025 payment rates varies significantly by region. This is in part driven by the change to the risk adjustment model for payment year (PY) 2025.

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 payment year 2024 and 2025. This is based on a static enrollment mix, so it only reflects changes in average star ratings by contract, and not a shift in enrollment toward plans with higher or lower star ratings. In addition, it does not include terminated contracts or contracts without a star rating.

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.

Part C Fee-for-Service (FFS) Normalization Factor and Risk Model Revision. PY2025 risk scores will be based on a 33%/67% blend of the v24/v28 CMS-HCC model. For 2025, CMS updated the FFS normalization methodology to use a multiple regression model which identifies years 2020 through 2023 as COVID affected years. Based on the Fact Sheet, CMS estimates the overall change to both the risk adjustment model and FFS normalization will be -2.45%. Please note, Wakely observed significant variation across MAO's due to the impact of the new risk adjustment model.

Change in Coding Pattern Adjustment. The coding pattern adjustment for 2025 will be kept at - 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.

In order to properly estimate the impact of the various MA payment components addressed in the Final Rate Announcement, 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 -0.12 %. 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 -0.26% (see Table 2).

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 Final Rate Announcement.
- Annual risk score coding trend is 0% for a static population.
- Nationwide average star ratings, which result in an average rebate percentage of 66.1% in 2024 and 65.5% for 2025.
- No consideration for sequestration.

Table 2 shows the calculations underlying our estimates.

Table 2 – Change in Risk Adjusted MA Bid Revenue

Item	2024	2025	2025/2024
1.0 MA Benchmark [1]	$1,147.45	$1,174.81	2.38%
Raw Risk Adjustment Factor [2]	1.0000	1.0000	0.00%
Risk Score Model Change	1.0000	0.9563	-4.37%
FFS Normalization	1.1028	1.0810	2.01%
MA Coding Pattern Adjustment	.9410	0.9410	0.00%
RAF after FFS Norm & Coding Pattern	0.8533	0.8324	-2.45%
Risk-Adjusted Benchmark	$979.14	$977.92	-0.12%
Assumed Risk-Adjusted Bid [3]	**$753.94**	**$753.00**	-0.12%
Savings (Benchmark less bid)	$225.20	$224.92	-0.12%
Rebate [4]	**$148.86**	**$147.43**	-0.96%
Risk-Adjusted Bid + Rebate	**$902.80**	**$900.43**	**-0.26%**

[1] Based on nationwide average MA enrollment by county as of March 2024

[2] Assumed no trend in risk scores

[3] Bid set at 77% of risk-adjusted benchmark

[4] 66.1% for 2024 and 65.5% for 2025

Attachment I: Final Estimates of the National Per Capita Growth Percentage and the National Medicare Fee-for-Service Growth Percentage for Calendar Year 2025

The final 2025 MA and FFS growth rates are shown in Table 3 and are compared with the Advance Notice and the 2024 growth rates.

Table 3 – Comparison of 2024 and 2025 Growth Rates

Component	2025 Final	2025 Advance Notice	2024 Final
MA Growth %	2.31%	1.98%	1.60%
Non-ESRD FFS Growth %	2.33%	2.57%	2.45%
ESRD FFS Growth %	1.76%	3.12%	2.27%

Both the Non-ESRD FFS ESRD and dialysis-only growth rates decreased from the Advance Notice. The MA Growth rate increased from the Advance Notice. CMS did not explain the drivers of these changes.

As has been the case in past years, the year over year change in Part C benchmarks can vary significantly depending on geographic area, plan star rating and applicable percentage. Table 4 shows the top five and bottom five growth rates by State (these changes include changes due to repricing/rebasing, direct graduate medical education (GME), kidney acquisition costs (KAC), indirect medical education (IME), Veteran's affairs and Department of Defense, credibility factors, star rating, double bonus status, applicable percentage, and the benchmark cap.

Table 4 - States with Highest and Lowest Benchmark Change

Rank	State	Change
51	MA	-0.8%
50	NH	-0.7%
49	MD	-0.6%
48	OH	-0.3%
47	RI	-0.1%
5	DE	4.3%
4	CA	4.3%
3	NY	4.5%
2	NV	5.5%
1	HI	6.2%

Attachment II: Key Assumptions and Financial Information

As in past years, CMS published projections for the total United State Per Capita Costs (USPCCs) by year. Projections are provided for all Medicare services combined as well as more detailed projections by service category within Part A and Part B.

Table 5 shows the restatements, from the Announcement of Calendar Year 2025, of the estimated Part A + Part B non-ESRD FFS costs for 2023 through 2025. Costs for 2023 and subsequent years restated downward, which lead directly to a lower growth rate than what would have been projected using the USPCC projections in the CY2024 Announcement. Note, in the CY2024 Announcement CMS decreased the expected per capita costs for 2023 and 2024 by about 2.1% from the CY2023 Announcement estimates.

Table 5 – Non-ESRD FFS Cost Estimates – CY2025 Final Announcement versus CY2024 Final Announcement

Year	CY2025 Final Announcement	CY2024 Final Announcement	Restatement
2023	$1,048.33	$1,057.70	-0.9%
2024	$1,085.48	$1,105.10	-1.8%
2025	$1,130.85	$1,149.98	-1.7%

In the CY2025 projections by service category for non-ESRD (Aged + Disabled), current estimates are lower than last year's estimates for all categories except for DME (+4%), Physician Administered Drugs (+8.2%) and Managed Care (+0.6%). The top 3 categories where current estimates decreased the most from last year's estimates are Carrier Lab (-19.8%), Intermediary Lab (-18.1%) and Other Carrier (-17.3%).

It is also interesting to note that CMS is continuing to project that Medicare Advantage (MA) enrollment will outpace the change in total Medicare beneficiaries for 2024 through 2027. In fact, MA enrollment has been consistently increasing since 2019 and is projected to continue to increase from 2025 to 2027. Table 6 shows the annual changes in CMS's projected enrollment for these years.

Table 6 – Projected Annual Percentage Change in Medicare Enrollment (non-ESRD, Part A)

Year	Total	FFS	MA
2025	2.2%	-1.2%	5.4%
2026	2.5%	1.0%	3.9%
2027	2.4%	0.8%	3.7%

Attachment III: Responses to Public Comments

Section A. General Comments

CMS received a large number of comments in response to the CY 2025 Advance Notice, with many supporting the proposal and others expressing concerns about the impacts of the proposed updates. Commenters who supported the proposal noted that the proposals provide financial integrity of the Medicare Trust Fund and stability to the MAPD programs. Commenters who did not support the proposed changes ranged from those who believed the growth rate implied overpayment to MA plans to those emphasizing the rate was too low and that these proposals could disrupt care, place the health of sicker, lower-income enrollees at risk, and result in increased costs and reduced benefits for MA enrollees.

In response, CMS provided the following information:

> CMS disagrees with commenters suggesting that the proposed policy changes would result in a payment cut. They continue to maintain their stance that the proposed polices were finalized using careful analyses with a commitment to health equity. They further note, that despite the 3.32 percent payment change in the CY2024 Rate Announcement, plan availability, choice, enrollment, and benefit offerings remained stable or grew in 2024.

Section B. Estimates of the MA and FFS Growth Percentages for CY 2025

Notable comments and CMS responses on 2025 growth rates include the following:

TECHNICAL UPDATE TO USPCC BASELINE REGARDING MA-RELATED MEDICAL EDUCATION EXPENSES COMMENTS AND RESPONSES:

A large number of commenters expressed concern regarding the continued phase in of the technical update to the USPCC baseline during a period when MA plans are experiencing higher utilization and costs. Many commenters recommended that CMS consider pausing or extending the phase-in period.

In response, the Secretary has directed the CMS OACT to change the phase in of the technical adjustment from 67 percent to 52 percent of the full adjustment.

ESTIMATES OF NON-ESRD USPCCS AND GROWTH RATES:

There were a significant number of comments regarding the USPCC projections and finalized growth rates.

There were several comments regarding the growth rate being lower than expected:

- Commenters reported that a large number of MAOs and ACOs have experienced increased utilization in the fourth quarter of 2024 and expressed concern that the growth rates did not reflect higher utilization and cost trends and the impacts of ongoing inflation that are expected to continue into 2025.
- Commenters expressed concern that the downward restated estimates of FFS costs compared to last year's estimates to be inconsistent with the higher utilization and costs seen in the U.S. health care market.
- Commenters cited specific causes of increased utilization and cost trend, such as vaccinations, Alzheimer treatments, uptick in Part B prescription drugs to treat cancer, use of GLP-1 drugs, other Part B pharmacy medical treatments, and increases in musculoskeletal, circulatory system and respiratory system surgeries.
- Commenters noted an analysis that observed FFS trends are greater than the growth rate and that the 2024 and 2025 growth rates are the lowest trends experienced since 2017, excluding 2022 (Which was impacted by COVID-19)

In response, CMS provided the following information:

- CMS sites section 1853 of the ACT which requires the Part C benchmark rates to be calculated based on FFS costs and sets the methodology to updating the UPSCC projections and growth rates. They further explain that the USPCC modeling reflects CMS's best estimate of historical program experience and projected trend and inflation.
- The baseline in the 2025 Advance Notice included claims incurred and paid through quarter three 2023. The baseline in the 2025 Rate Announcement includes incurred data through quarter three and paid data through quarter four.
- CMS acknowledged they are aware of numerous reports from MAOs stating that MA trends have increased significantly in quarter four of 2023. They further state that they are not aware of the drivers accounting for the claims of the MAOs. CMS reviewed incomplete fourth quarter 2023 FFS incurred experience and it was consistent with the projections.
- They also recall a statement made in 2024 Rate Announcement, which explained that over the last several years, a greater proportion of dual eligibles have enrolled in MA plans which has decreased the average FFS per capita cost for inpatient, SNF and home health spending and may be contributing to the faster spending growth for some MAOs.

There were additional comments stating the growth rates are not in line with other available data sources such as the National Health Expenditure (NHE) projections of Medicare spending, Congressional Budget Office (CBO) estimates of Medicare spending, published projections by actuarial firms or MAOs, Trustees Report, etc. In response, CMS states there are differences in

timing and the underlying population and services covered between the USPCCs and other data sources.

Lastly, several commenters expressed concern regarding the level of transparency of the analysis and assumptions used to calculate the growth percentages. CMS believes the information provided in the Advance Notice and Rate Announcement provides the necessary support for understanding USPCC levels and trends.

ESRD DIALYSIS-ONLY USPCC AND GROWTH RATE:

A few commenters requested CMS provide additional detailed implementation regarding the methodology and assumptions used to develop the ESRD growth rates and expressed concerns regarding the volatility of the ESRD growth percentages. In addition, there were a few concerns regarding the adequacy of the ESRD rates relative to the cost of providing care.

In response, CMS provided the following information:

- Starting in 2024, CMS has added trends for the ESRD Prospective Payment System base rate in the published unit cost increases. The volatility in recent years is driven by the COVID-19 pandemic, specifically pre-pandemic expectations not aligning with actual experience.
- They further explained the ESRD dialysis USPCCs are projected using CY2022 USPC, trended to 2025 using ESRD growth with an adjustment factor for dialysis only. The utilization and intensity assumptions supporting the ESRD trends are based on multiple years of historical experience.

Several commenters requested clarification whether the costs of oral-only ESRD drugs paid under Part B in CY2025 are accounted for in the development of the rates.

In response, CMS provided the following information:

- CMS included a 2.47 percent increase in the Part B dialysis USPCC projection to account for these oral-only ESRD drugs.

There were a few comments which expressed concerns regarding the treatment of Transitional Drug Add-on Payment Adjustment (TDAPA) and Transitional Add-On Payment Adjustment for New and Innovative Equipment and Supplies (TPNIES) under the ESRD PPS and suggested that CMS reimburse dialysis facilities directly for MA beneficiaries.

In response, CMS provided the following information:

- The CY 2025 ESRD dialysis-only FFS USPCC reflects the best estimate of national per-capita cost, including changes to the ESRD PPS bundled payments, including the TDAPA and the TPNIES.

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

There were a couple of comments expressing concern regarding the impact of the lump sum payments to MA plans, if providers expect similar recoveries from MA plans, and the prospective negative adjustments to future growth rates. CMS's response remains that there is no impact to 2025 growth rates, and that they will consider impact of the 340B Remedy Rules on MA rates for future policy years.

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

Several commenters expressed concerns about benchmark calculations imposed by the ACA and how it limits health plans' ability to improve coverage for enrollees including adding supplemental benefits and reducing cost sharing.

In response, CMS stated that they have not identified discretion under section 1853(n)(4) of the Act to eliminate application of pre-ACA rate caps or exclude the bonus payment from the cap calculation.

Section D. Calculation of Fee-for-Service Costs

There was an increased number of comments on whether it is appropriate for CMS to calculate the FFS costs used for Part C benchmark rates using Part A only and B only beneficiaries versus also including Part A and Part B only beneficiaries. CMS has included a similar response as in prior years and will not be making a change.

The Advance Notice sought public comment on the possibility of adjusting FFS experience in Puerto Rico to reflect to propensity of zero-dollar beneficiaries nationwide. CMS has updated the study to incorporate the Secretary's instructions. The zero-claim adjustment for Puerto Rico will be 4.2 percent for 2018 through 2022 and is included in the CY 2025 ratebook development.

There was also an increased number of comments regarding the Puerto Rico benchmark rates being significantly lower than the mainland. CMS did not make any additional changes for Puerto Rico for CY2025.

Section E. Direct Graduate Medical Education

Commenters were concerned about the proposed change for the Maryland TCOC Model, indicating that the current methodology has been helpful to MAOs to manage revenue shortfalls and the quartile adjustments in Maryland. The commenters believe the proposed changes to the AGA factors would remove financial value for MAOs in Maryland. CMS indicated that the methodological change is necessary to adhere to the statutory requirements under 1853(c) and 1853(n) of the Act.

Section F. Organ Acquisition Costs for Kidney Transplants

CMS indicated that they would continue to monitor the amount of kidney acquisition costs to determine whether refinements and improvements to the methodology for the carve-out adjustment are warranted.

Section G. IME Phase Out

CMS referred readers to Attachment III Section B for their responses to comments related to IME phase out.

Section H. MA ESRD Rates

Commenters raised the concern that the current ESRD payment rates are not sufficient to cover associated costs and made different suggestions to change the payment calculation. Suggestions included utilizing smaller geographic areas, applying the quality bonus payment (QBP) or applicable percentages to ESRD rates, and adjusting rates to reflect the impact of the Maximum Out-of-Pocket (MOOP) requirement in the MA program.

CMS rejected these concerns and suggestions for 2025 and said it would continue to analyze whether “any refinements to the methodology may be warranted in future years.” More specifically, CMS noted it believed that applying QBP, applicable percentage or MOOP adjustments would be inconsistent with Section 1853 of the Social Security Act.

Section I. MA EGWPs

Plan sponsors will not need to file EGWP bid pricing tools (BPTs) for CY2025, as was the case in CY2024. CMS finalized the EGWP Bid-to-Benchmark Ratios as proposed in the Advance Notice.

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

CMS intends to continue its three-year phase in of the 2024 CMS-HCC model stating the method is consistent with phased in model updates in the past. As indicated previously, the 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.

CMS clarified that the capitated payment system is to be expected to reduce morbidity and mortality through early detection and should not be driving clinical behavior. The goal of the 2024 CMS-HCC model change was to refresh the CMS-HCC model to reflect current disease patterns, treatment methods, diagnoses, and coding practices. The hierarchical condition categories (HCCs) increased from 204 (86 for payment) to 266 (115 for payment) reflecting approximately 74,000 ICD-10-CM codes.

CMS reduced the number of ICD-10-CM codes reflected in the 2024-CMS-HCC compared to the 2020 CMS-HCC model by about 20%. The reduction reflects the evaluation of the diagnosis in accordance with CMS risk adjustment principles. More detail is available in the CY 2024 Rate Announcement.

CMS addressed concerns about the disproportionate impact of the new model on Puerto Rico with general comments. Most significantly, CMS acknowledged the high percentage of beneficiaries in Puerto Rico considered full dual. The CMS-HCC risk adjustment model implemented in 2017 that adjusts risk scores based on dual-eligibility status – ensuring higher payments for dual-eligible compared to non-duals for the same disease states – remains in use. By CMS estimates, using the 2024 CMS-HCC model, results in less change for dually eligible beneficiaries compared to the change in risk scores for non-dual eligible beneficiaries when the risk model adjustment, normalization impact, and MA risk score trend are all considered.

Commenters were concerned about the 2024 CMS-HCC model negatively impacting providers engaged in value-based payment models. Payment arrangements between MA organizations and providers are not governed by CMS so the response focused on the responsibility of MA organizations to provide coverage for Medicare Part A and Part B services and providers to accurately diagnose and code using ICD coding guidelines.

To address the -4.44 percent model phase-in impact noted in the FAQs associated with the CY 2025 Advance Notice, CMS described the calculation of the raw risk adjustment model revision phase-in and reminded readers that the phase-in represented 33 percent of risk scores under the 2024 CMS-HCC model in CY 2024 and 67 percent of the risk scores under the 2024 CMS-HCC model in CY 2025.

CMS believes the 2024 CMS-HCC model is an improved model for equitably directing resources needed to plan to support beneficiaries' health care needs.

PACE ORGANIZATIONS

CMS will continue to use the 2017 CMS-HCC model to calculate risk scores in CY 2025 for PACE organizations.

PACE organizations have received technical instructions for submitting encounter data (EDS). CMS intends to transition PACE organizations from RAPS to EDS for the purpose of risk adjusting. No timeline was provided for the transition.

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

PACE ORGANIZATIONS

CMS did not receive comments on the CMS-HCC ESRD risk adjustment models for PACE organization for CY 2025. For ESRD beneficiaries in PACE plans, CMS will continue to use the CY 2019 CMS-HCC ESRD risk adjustment models as proposed in the Advance Notice.

NON-PACE ORGANIZATIONS

CMS intends to continue calculating risk scores for payment of beneficiaries with ESRD in MA plans and certain demonstrations using the CY 2023 CMS-HCC ESRD risk adjustment models as proposed in the Advance Notice

Section L. Frailty Adjustment for PACE Organizations and FIDE SNPs

For FIDE SNPs in CY 2025, CMS will use only the full Medicaid frailty factors to calculate FIDE SNP frailty scores.

For PACE organizations in CY 2025, CMS will continue to use the frailty factors associated with the 2017 CMS-HCC model to calculate frailty scores.

Section M. Medicare Advantage Coding Pattern Adjustment

CMS is finalizing the proposed adjustment of 5.9 percent for CY 2025.

Section N. Normalization Factors

CMS is finalizing the methodology for the normalization factors for the CMS-HCC and CMS-HCC ESRD risk adjustment models as proposed in the Advance Notice.

Attachment IV: Responses to Public Comments on Part D Payment Policy

Attachment IV contains a summary of comments received by CMS on Part D Policy announcements in the Advance Notice and CMS's responses to these comments.

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

As laid out in the Advance Notice, beginning in CY 2025, the IRA eliminates the coverage gap phase and sets the annual OOP threshold at $2,000. The defined standard Part D prescription drug coverage in CY 2025 will now consist of a three-phase benefit consisting of the deductible, initial coverage phase, and catastrophic coverage phase. Beneficiaries will continue to pay no cost sharing for covered Part D drugs in the catastrophic coverage phase.

CMS acknowledged in their responses to comments that the Part D redesign may lead to changes in the Part D market. They believe the redesign will improve drug affordability and reduce OOP costs for Part D beneficiaries. As the IRA impacts are observed in the PDE experience and projected for the periods in future contract years, they will also consider how to account for possible induced utilization changes.

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 Discount Program. No in-scope comments were submitted.

Section C – Part D Premium Stabilization

As enacted by the IRA, the 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.

Commentors noted potential for significant beneficiary impacts in plans that incur larger than average premium increases due to the Part D redesign. They encouraged CMS to seek additional mechanisms to assist Part D sponsors in successfully implementing the redesign. CMS acknowledged that Part D plans may have premium changes different from the average, but the IRA does not provide CMS with a mechanism to reduce the variation in basic Part D premiums.

Section D. Part D Calendar Year EGWP Prospective Reinsurance Amount

From the Advance Notice and 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

CMS stated that per 1860D of the Social Security Act, CMS cannot establish a risk corridor with narrower thresholds relative to the CY2011 thresholds.

Section F. Retiree Drug Subsidy Amounts

No comments or changes to the Advance Notice.

Section G. RxHCC Model Risk Adjustment Model

One commenter challenged CMS' removal of oral-only ESRD drugs from the calibration of the CY2025 RxHCC model since the CY2025 ESRD PPS Final Rute is not yet published and there is a chance that it could overrule current law that prescribes that these drugs be covered under Part B beginning in 2025. CMS responded that they always use current law at the time of model calibration.

Several commenters expressed concerns that the IRA Part D redesign will change beneficiary behavior as it may incentivize usage of more expensive drugs that would not be captured in the historical data used for the CY2025 RxHCC model calibration. CMS responded that they believe any assumptions for expected behavior changes would introduce too much error and prefers to wait to account for any behavior changes in future iterations of the model once the data is available.

Section H. Normalization Factors for the RxHCC Models

Several commenters suggested that including beneficiaries in SNPs within the normalization factor calculation but not including them in the NAMBA calculation may create premium distortions. CMS responded by saying that the low-income premium subsidy protects low-income beneficiaries from paying basic Part D plan premiums, and that it is not appropriate to exclude any populations from the normalization factor calculation as the goal of normalization is to average to 1.0 risk score across the entire market.

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

Attachment V contains the annual adjustments to the Part D Defined Standard benefit parameters. Two annual percentage adjustments are calculated to develop the CY 2025 benefit parameters: the annual percentage increase (API) and the annual Consumer Price Index (CPI) increase. These adjustments are described below.

Section A. Annual Percentage Increase in Consumer Price Index (CPI)

The CPI 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 B. Calculation Methodology

For the CY2025 benefit parameters, Part D program data will be used 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 consumer price index (CPI) for September 2025 is the combination of the projected trend for September 2024 (2.61%) and a multiplicative prior year revision of -0.011% for a total annual percentage increase of 2.50%.

Section C. Annual Percentage Increase in Average Expenditures for Part D Drugs per Eligible Beneficiary (API)

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

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 CY 2025, the retiree subsidy cost threshold is $590 (was $545 in 2024) and the cost limit is $12,150 (was $11,200 in 2024).

Attachment VI: 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) being used.

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 Measures for Future Years (2026 Star Ratings and later)

CMS is working to align the Universal Foundation measures with the Medicare Star Ratings. As a reminder, all Universal Foundation measures are expected to become a part of the Part C and D Star Ratings, pending future rulemaking. Of the four Adult Universal Foundation 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)). Commenters largely support this measure alignment but raised concerns with data quality and collection challenges.

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 2025. 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 (2027 Star rating at the earliest). Commenters were supportive of this proposed change but advised NCQA to wait for the final recommendation of the U.S. Preventive Services Task Force.

Care for Older Adults – Pain Assessment (Part C) – NCQA is retiring this measure in the 2025 measurement year. CMS will remove this measure when it is retired (2027 Star Ratings).

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. If these changes are incorporated, the legacy measures would remain in the Star Ratings until the updated measures have been on the display page for at least two years. The majority of commenters supported these changes.

Care Coordination (Part C) – CMS is considering updating the questions for this measure, derived from the CAHPS survey, after favorably field-testing in 2022. No timeline was specified. If these changes are made, the existing measure would be removed from the Star Ratings while the updated measure is on the display page for two years. Many commenters supported these changes but had suggestions for adjustments.

- 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) – Change in data source for 2026 Star Ratings
    - Members Choosing to Leave the Plan (Part C and D) – Adjustment of the measurement period for 2026 Star Ratings
    - Getting Appointments and Care Quickly (Part C) – Removal of one of the three questions for 2027 Star Ratings
    - Diabetes Care – Eye Exam (Part C) – NCQA plans to update the eye exam clinical codes in measurement year 2025 (2027 Star Ratings) as part of their move toward digital. Commentators had mixed reaction to the updates as it would also remove the hybrid reporting methodology for 2027 Star Ratings
    - Statin Use for Patients with Cardiovascular Disease (Part C) – Exclusion of members with history of statin intolerance for 2027 Star Ratings and re-evaluation of measure for 2028 Star Ratings

- The following measures have been submitted to the 2023 Pre-Rulemaking Measure Review process and may be added to Star Ratings program through future rulemaking:
    - Initiation and Engagement of Substance Use Disorder Treatment (Part C)
    - Initial Opioid Prescribing for Long Duration (Part D)

Display Measures

Display measures are published separately from the Star Ratings. Many of them are new or updated measures to be included in the Star Ratings after a two- year preview period. CMS anticipates all 2024 display measures will continue to be shown on CMS.gov in 2025 unless noted.

CMS is adding the following HEDIS measure to the display page for 2025 Star Ratings.

Social Need Screening and Intervention (Part C) – NCQA may expand this measure with a new an indicator for insecurity. This proposed change is getting mixed reactions, ranging from concerns with data availability to enhancements as a triple weighted measure.

NCQA is considering updates to the measure specifications for the following HEDIS Display measures with measurement year 2025:

- Follow-Up After Hospitalization for Mental Illness (Part C) – Some commentators oppose expanding the denominator to include secondary mental health diagnosis.
- Adult Immunization Status (Part C) – support for the measure overall was mixed.

The following Part D Display measures will be updated for the 2024 measurement year to align with PQA measure specification updates. Commentators supported this effort.

- Polypharmacy: Use of Anticholinergic Medications in Older Adults (Poly-ACH) (Part D).
- Polypharmacy: Use of Multiple CNS-Active Medications in Older Adults (Poly-CNS) / Poly-ACH (Part D).
- Use of Opioids at High Dosage in Persons Without Cancer (OHD) / Use of Opioids from Multiple Providers in Persons Without Cancer (OMP) / Concurrent Use of Opioids and Benzodiazepines (COB) / Initial Opioid Prescribing for Long Duration (IOP-LD) (Part D).

CMS will align with the PQA measure specifications to use continuous enrollment for these display measures and no longer adjust for MYs with 2024 and 2025 measurement periods respectively.

- Poly-CNS / Poly-ACH / COB / OHD / OMP (Part D) - 2024
- Medication Adherence for HIV/AIDS (Antiretrovirals) (ADH-ARV)/Antipsychotic Use in Persons with Dementia, Overall (APD)/Antipsychotic Use in Persons with Dementia, in Long-Term Nursing Home Residents (APD-LTNH)/Use of Opioids at High Dosage in Persons without Cancer (OHD)/Use of Opioids from Multiple Providers in Persons without Cancer (OMP)/Initial Opioid Prescribing -Long Duration (IOP-LD) (Part D) -2025

CMS will change the data sources for identification of hospice stay and/or ESRD status to the Common Medicare Environment (CME) from the Enrollment Database (EDB) with measurement year 2024 (2026 Star Rating) for the following Display measures:

- OHD/ OMP/Persistence to Basal Insulin (PST-INS)/ADH-ARV/COB/IOP-LD/Poly-CNS/Poly-ACH (Part D)

The following measures will be retired from the Display Page:

- Antidepressant Medication Management (Part C).
- Use of Opioids from Multiple Providers in Persons Without Cancer (OMP) (Part D).

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. Commentators appreciate the updates to these measures but shared concerns that with overlap and redundancy with other measures.
- Medicare Plan Finder (MPF) 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. The MPF - Stability display measure will be retired at that time.

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.

- New 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. Commenters had several concerns with the proposed measure, especially the electronic data collection.

- Breast Cancer Screening Follow-Up is in development for measurement year 2025. Most commenters supported the development of the but expressed concern with the electronic reporting method.
- The development of the new Social Connection Screening and Intervention measure (Part C) has been paused for measurement year 2025 until first year analysis of the SNS-E is conducted in the summer of 2024. Commenters had mixed reactions to this measurement concept due to lack of data and standardization.
- 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. NCQA has paused further measure development work. Commenters had mixed reactions to this measurement concept, raising challenges around encouraging overprescribing of opioids.
- Tobacco Use Screening and Cessation and Lung Cancer Screening and Follow-Up (Part C) are underdevelopment and targeted for release in measurement year 2026. CMS is considering adding them to the MA Star Rating program through future rulemaking. Commenters supported these measurement concepts and made various other suggestions.
- Functional Status Assessment Follow-Up (Part C) is planned for implementation in measurement year 2026 at the earliest. Commenters supported these measurement concepts but asked for additional information.

Attachment VII: Economic Information for the CY 2025 Rate Announcement

Attachment VII provides economic information for significant Rate Announcement provisions. Items not identified in Attachment VII indicate a continuation of CY 2024 policies, so have not been called out in this section of the final announcement. Following are changes from the CY 2025 Advance Rate Notice.

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

- Medicare Advantage and PACE non-ESRD Ratebook.
- Growth rate for 2025 FFS non-ESRD rates estimate: **2.33%, a change from 2.57% in the Advance Notice**

- Growth rate for 2025 MA non-ESRD rates estimate: **2.31%, a change from 1.98% in the Advance Notice.**
- Net impact $8.8 billion cost to Medicare Trust Funds down from 9.2 billion in the Advance Notice.
- MA growth percentage used to calculate the 2024 PACE non-ESRD is estimated to be **2.31%, a change from 1.98% in the Advance notice**.
    - Net Impact $60 million cost to Medicare Trust Funds – **up from $40 Million in the Advance Notice.**
- Continue 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- **no change from the Advance Notice.**

A1. Medicare Advantage and PACE ESRD Ratebooks.

- FFS growth percentage for the 2025 MA ESRD rates is estimated to be **1.76% a change from 3.12% in the Advance Notice**.
    - Net impact $550 million cost to Medicare Trust Funds, a change from $730 million in the Advance Notice.

A2. CMS-HCC Risk Adjustment Model.

- CMS is finalizing the CY 2025 risk scores for non-PACE Part C organizations to 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, No change from the Advance Notice.
    - Represents $9.2 billion net savings to the Medicare Trust Fund in 2025, No change from the Advance Notice
    - 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.

A3. ESRD Risk Adjustment.

- Same as in Advance Notice

A4. Frailty Adjustment for FIDE SNPs

- CMS is finalizing the CY 2025 frailty scores for FIDE SNPs to 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%, same as the Advance Notice**
    - Represents a net cost of less than $10 million to the Medicare Trust Funds in 2025, same as the Advance notice.
        - Since enrollment will be limited to full-benefit dually eligible individuals for FIDE SNPS, CMS is proposing only the full Medicaid frailty factors be used in the calculation.

A5. MA Coding Pattern Difference Adjustment

- Continue to apply statutory minimum coding patter difference adjustment: 5.9%.
- No year-over-year impact.

A6. Part C Normalization

- To maintain a 1.0 average FFS risk score across all CMS-HCC risk adjustment models, CMS is proposing to calculate the normalization factors using a five-year multiple linear regression methodology and average historical FFS risk scores from 2019 through 2023 for the CY 2025 model.
    - The impact of Normalization is zero

Section B – Changes in the Payment Methodology for Medicare Part D for CY 2024

B1. Annual Percentage Increase for Part D Parameters

- Generally unchanged from CY 2024
- At current time, the lowering of the OOP threshold to $2,000 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.
- 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.
- For CY 2025, for the RxHCC models, CMS is proposing to calculate normalization factors using the longstanding five-year linear slope methodology and average historical risk scores from 2018 through 2022, excluding 2021 for the model proposed for non-PACE organizations, and from 2016 through 2020 for the model proposed for PACE organizations.
    - The impact of normalization is $0.

Attachment VIII: RxHCC Risk Factors and Predictive Ratio Tables

No changes from Advance Notice.