April 1, 2024

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

**Announcement of Calendar Year (CY) 2025 Medicare Advantage (MA) Capitation Rates and Part C and Part D Payment Policies**

In accordance with section 1853(b)(1) of the Social Security Act ("the Act"), we are notifying you of the annual capitation rate for each Medicare Advantage (MA) payment area for CY 2025 and the risk and other factors to be used in adjusting such rates.

In response to our request for comments on the Advance Notice of Methodological Changes for CY 2025 MA Capitation Rates and Part C and Part D Payment Policies (CY 2025 Advance Notice), published on January 31, 2024, CMS received submissions from professional organizations, MA and Part D sponsors, advocacy groups, physicians, state Medicaid agencies, pharmaceutical manufacturers, pharmacy benefit managers, pharmacies, and interested persons. The Rate Announcement describes and responds to all of the substantive comments received.

After considering all comments received, we are finalizing policies in the Announcement of CY 2025 MA Capitation Rates and Part C and Part D Payment Policies (CY 2025 Rate Announcement) that reflect CMS' commitment to ensuring that people with Medicare receive equitable, affordable, high quality, and whole person care now and in the future, especially the most vulnerable. The policies in the CY 2025 Rate Announcement are an important step in our efforts to make sure the MA and Part D programs meet the health care needs of all beneficiaries while improving the quality and long-term stability of the Medicare program. For instance, the CY 2025 Rate Announcement finalizes a new Part D risk adjustment model that reflects the changes made to the Part D benefit by the Inflation Reduction Act of 2022 (IRA) (Pub. L. 117-169) that take effect in CY 2025, including a new $2,000 out of pocket cap.

The capitation rate tables for CY 2025 and supporting data are posted on the CMS website at https://www.cms.gov/Medicare/Health-Plans/MedicareAdvtgSpecRateStats/Ratebooks-and-Supporting-Data.html. The statutory component of the regional benchmarks, qualifying counties, and each county's applicable percentage are also posted on this section of the CMS website.

Attachment I of the Rate Announcement shows the final estimates of the National Per Capita MA Growth Percentage for CY 2025 and the National Medicare Fee-for-Service (FFS) Growth Percentage for CY 2025, used to calculate the CY 2025 capitation rates. As discussed in Attachment I, the final estimate of the National Per Capita MA Growth Percentage for combined aged and disabled beneficiaries is 2.31 percent, and the final estimate of the FFS Growth Percentage is 2.33 percent. Attachment II provides a set of tables that summarizes many of the key Medicare assumptions used in the calculation of the growth percentages.

Section 1853(b)(4) of the Act requires CMS to release county specific per capita FFS expenditure information on an annual basis, beginning with March 1, 2001. In accordance with this requirement, FFS data for CY 2022 were posted on the above website with the Advance Notice.

Attachment II details the key assumptions and financial information behind the growth percentages presented in Attachment I.

Attachment III presents responses to Part C payment-related comments on the CY 2025 Advance Notice.

Attachment IV presents responses to Part D payment-related comments on the CY 2025 Advance Notice.

Attachment V provides the final Part D benefit parameters and details how they are updated.

Attachment VI presents responses to comments on updates for MA and Part D Star Ratings.

Attachment VII contains economic information for significant provisions in the CY 2025 Rate Announcement.

Attachment VIII contains the RxHCC model risk adjustment factors and predictive ratio tables.

Attachment IX contains the 2024 CMS-HCC model predictive ratio tables.

**Key Updates from the Advance Notice**

Growth Percentages: Attachment I provides the final estimates of the National Per Capita MA Growth Percentage and the FFS Growth Percentage, upon which the capitation rates are based, and information on deductibles for Medical Savings Accounts. Each year for the Rate Announcement, CMS updates the growth rates to be based on the most current estimate of per capita costs, based on the available historical program experience and projected trend assumptions at that time. The growth rates change between proposed and final as CMS incorporates updated data and assumptions. This year, the change in growth rates from the Advance Notice to the Rate Announcement is due primarily to incorporation of additional

payment data, including through the fourth quarter of 2023. This updated payment data moderately increased spending for some categories and decreased spending for others. Additionally, the enrollment base used to calculate 2023 per capita costs was updated for the Rate Announcement and resulted in greater Part A enrollment.

> Technical Update to Medical Education Payments in the Non-End Stage Renal Disease (ESRD) USPCC Baseline: The Secretary has directed the CMS Office of the Actuary (OACT) to continue to phase in the technical update that removes MA-related indirect medical education and direct graduate medical education costs from the historical and projected expenditures supporting the final estimates (being released in this Rate Announcement) of the non-ESRD FFS USPCCs, with 52 percent of the medical education adjustment applied to the USPCCs in 2025.

**Policies Adopted as Described**

As in past years, policies in the Advance Notice that are not modified or retracted in the Rate Announcement become effective for the upcoming payment year. Clarifications in the Rate Announcement supersede information in the Advance Notice and prior Rate Announcements as they apply for CY 2025.

Calculation of FFS Costs: The Secretary has directed the CMS OACT to adjust the FFS experience for beneficiaries enrolled in Puerto Rico to reflect the propensity of "zero–dollar" beneficiaries nationwide.

MA Benchmark, Quality Bonus Payments, and Rebate: We will continue to implement the methodology, as described in the CY 2025 Advance Notice, used to derive the benchmark county rates, how the qualifying bonus counties are identified, and the applicability of the Star Ratings.

Location of Network Areas for Private Fee-for-Service (PFFS) Plans in Plan Year 2026: The list of network areas for plan year 2026 is available on the CMS website at https://www.cms.gov/medicare/health-drug-plans/private-fee-for-service-plans/network-requirements.

Direct Graduate Medical Education (DGME) Carve-out Applied to Average Geographic Adjustments (AGAs): As in past years, we will continue carving out FFS DGME amounts from the MA capitation rates. As described in the CY 2025 Advance Notice, we will use a different data source and methodology to develop the DGME amounts to carve out for hospitals participating in the Maryland Total Cost of Care (TCOC) Model. (This is different than the technical update related to medical education payments on behalf of MA enrollees in the non-ESRD USPCC baseline discussed above.)

Organ Acquisition Costs for Kidney Transplants: We will continue carving out Kidney Acquisition Costs (KAC) from the MA capitation rates.

Indirect Medical Education (IME) Phase Out Applied to AGAs: We will continue phasing out FFS IME amounts from the MA capitation rates. As described in the CY 2025 Advance Notice, we will use a different data source and methodology to develop the IME amounts to phase out for hospitals participating in the Maryland TCOC Model.

MA ESRD Rates: We will continue to set MA ESRD rates on a state basis.

MA Employer Group Waiver Plans (EGWPs): We will continue to use the payment methodology as described in the Advance Notice, but with finalized bid-to-benchmark ratios for CY 2025 MA EGWP Payment rates as indicated in the table below.

| Applicable Percentage | Bid to Benchmark Ratio |
|---|---|
| 0.95 | 78.5% |
| 1 | 76.7% |
| 1.075 | 76.1% |
| 1.15 | 76.5% |

CMS-Hierarchical Condition Categories (CMS-HCC) Risk Adjustment Model (Non-PACE): CMS is finalizing the continuation of the phase-in of the 2024 CMS-HCC model as proposed in the CY 2025 Advance Notice by blending 67 percent of the risk score calculated using the updated 2024 CMS-HCC risk adjustment model with 33 percent of the risk score calculated using the 2020 CMS-HCC risk adjustment model.

CMS-HCC Risk Adjustment Model (PACE): For CY 2025, CMS will continue to use the 2017 CMS-HCC risk adjustment model and associated frailty factors to calculate risk scores for participants in PACE organizations.

CMS-HCC ESRD Risk Adjustment Models:

- For Non-PACE Organizations: For CY 2025, CMS will continue to use the 2023 CMS-HCC ESRD risk adjustment models to calculate risk scores for beneficiaries in dialysis, transplant, and post-graft status.

- For PACE Organizations: For CY 2025, CMS will continue to use the 2019 CMS-HCC ESRD risk adjustment models to calculate risk scores for participants in PACE organizations with ESRD.

Frailty Adjustment for PACE Organizations: For CY 2025, CMS will continue to use the frailty factors associated with the 2017 CMS-HCC model (refer to Table II-9 in the CY 2025 Advance Notice) to calculate frailty scores for PACE organizations.

Frailty Adjustment for Fully Integrated Dual Eligible Special Needs Plans (FIDE SNPs): For CY 2025, CMS will continue to use the frailty factors associated with the 2024 CMS-HCC model and the 2020 CMS-HCC model (refer to Tables II-7 and II-8 in the CY 2025 Advance Notice) to calculate frailty scores for FIDE SNPs. Also, consistent with CMS' proposal to blend risk scores for CY 2025 (67 percent 2024 CMS-HCC model and 33 percent 2020 CMS-HCC model), a blended frailty score for FIDE SNPs will be compared with PACE frailty calculated in the same manner to determine whether that FIDE SNP has a similar average level of frailty as PACE.

MA Coding Pattern Difference Adjustment: For CY 2025, CMS will continue to apply the statutory minimum MA coding pattern difference adjustment of 5.90 percent.

Final CY 2025 CMS-HCC Risk Adjustment Model Normalization Factors: CMS will finalize the CY 2025 Normalization Factors as proposed in the CY 2025 Advance Notice.

For CY 2025, for all CMS-HCC risk adjustment models, CMS calculated the normalization factors using a five-year multiple linear regression methodology and average historical FFS risk scores from 2019 through 2023.

- 2024 Part C CMS-HCC Model: 1.045
- 2020 Part C CMS-HCC Model: 1.153
- 2017 Part C CMS-HCC Model: 1.157
- 2023 ESRD Dialysis CMS-HCC Model: 1.044
- 2019 ESRD Dialysis CMS-HCC Model: 1.103
- 2023 ESRD Functioning Graft Model: 1.074
- 2019 ESRD Functioning Graft Model: 1.159

Sources of Diagnoses for Risk Scores Calculated with CMS-HCC and CMS-HCC ESRD Risk Adjustment Models:

- For Non-PACE organizations: CMS will continue the policy first adopted for CY 2022 to calculate all 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: CMS will continue using the same method of calculating risk scores that we have been using 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.

RxHCC Risk Adjustment Models: For CY 2025, CMS will implement the updated version of the RxHCC risk adjustment model proposed in the CY 2025 Advance Notice that incorporates changes made to the Part D benefit for CY 2025 as a result of the IRA.

- For Non-PACE organizations: CMS will implement the model calibrated on 2021 diagnoses and 2022 expenditure data as proposed in the CY 2025 Advance Notice.

- For PACE organizations: CMS will implement the model calibrated on 2018 diagnoses and 2019 expenditure using specialty-based filtering logic. In addition, the RxHCC model for PACE organizations incorporates the clinical update proposed in the CY 2025 Advance Notice that aligns the model used for PACE organizations with the model used for Non-PACE organizations.

Final CY 2025 RxHCC Risk Adjustment Model Normalization Factors: For CY 2025, for the RxHCC models, CMS calculated separate normalization factors for Medicare Advantage prescription drug (MA-PD) plans and stand-alone Medicare Part D prescription drug plans (PDPs), using the long-standing five-year linear slope methodology and average historical risk scores from 2018 through 2022, excluding 2021 for the RxHCC model being finalized for Non-PACE organizations, and from 2016 through 2020 for the RxHCC model being finalized for PACE organizations. We will use the factor that would be used for MA-PD plans for use in calculating risk scores for PACE organizations.

- 2025 RxHCC model for organizations other than PACE:
    - MA-PD plans: 1.073
    - PDPs: 0.955
- 2025 RxHCC model for PACE organizations: 1.163

Source of Diagnoses for Risk Scores calculated with the RxHCC Risk Adjustment Models:

- For Non-PACE organizations: CMS will continue the policy first adopted for CY 2022 to calculate all 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: CMS will continue using the same method of calculating risk scores that we have been using 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) RAPS data, and (3) FFS claims.

Annual Adjustments to Medicare Part D Benefit Parameters in 2025: As described in the CY 2025 Advance Notice, we will update the defined standard benefit deductible amount by

multiplying the CY 2023 amounts by the CY 2024 Annual Percentage Increase (API) and rounding as specified by the statute.

Part D Calendar Year EGWP Prospective Reinsurance Amount: As proposed in the Draft CY 2025 Part D Redesign Program Instructions, and as finalized in the Final CY 2025 Part D Redesign Program Instructions published concurrently with this Rate Announcement[1], we will update the methodology used to calculate the prospective reinsurance payments to all Part D Calendar Year EGWPs as described.

Part D Risk Sharing: As discussed in the CY 2025 Advance Notice, we will apply no changes to the current threshold risk percentages for CY 2025.

Retiree Drug Subsidy Amounts: As discussed in the CY 2025 Advance Notice, we will use the same methodology as in prior years to update the cost threshold and cost limit for qualified retiree prescription drug plans.

/ s /
Meena Seshamani, M.D., Ph.D.
Director, Center for Medicare

I, Jennifer Wuggazer Lazio, am a Member of the American Academy of Actuaries. I meet the Qualification Standards of the American Academy of Actuaries to render the actuarial opinion contained in this Rate Announcement. My opinion is limited to the following sections of this Rate Announcement: The growth percentages and United States per capita cost estimates provided and discussed in Attachments I, II and III; the qualifying county determination, calculations of Fee-for-Service cost, direct graduate medical education carve-out, kidney acquisition cost carve-out, IME phase out, MA benchmarks, EGWP rates, and ESRD rates discussed in Attachment III; the Medicare Part D Benefit Parameters: Annual Adjustments for Defined Standard Benefit in 2025 described in Attachments IV and V; and the economic information contained in Attachment VII. As described in Attachment III of this Rate Announcement, the Secretary has directed the CMS Office of the Actuary to phase in the MA-related medical education technical adjustment to the USPCCs that are used in determining the growth percentages.

/ s /
Jennifer Wuggazer Lazio, F.S.A., M.A.A.A.

[1] Refer to CMS' Draft CY 2025 Part D Redesign Program Instructions and Final CY 2025 Part D Redesign Program Instructions.

Director
Parts C & D Actuarial Group
Office of the Actuary

Attachments

**2025 RATE ANNOUNCEMENT**

**Attachment I. Final Estimates of the National Per Capita Growth Percentage and the National Medicare Fee-for-Service Growth Percentage for CY 2025**

Table I-1 below shows the National Per Capita MA Growth Percentage (NPCMAGP) for CY 2025. An adjustment of -1.29 percent for the combined aged and disabled cohort is included in the NPCMAGP to account for corrections to prior years' estimates as required by section 1853(c)(6)(C). The combined aged and disabled change is used in the development of the ratebook.

**Table I-1. Increase in the NPCMAGP for CY 2025**

| | Prior increases | Current increases | | | NPCMAGP for 2025 with §1853(c)(6)(C) adjustment[1] |
|---|---|---|---|---|---|
| | 2003 to 2024 | 2003 to 2024 | 2024 to 2025 | 2003 to 2025 | |
| Aged + Disabled | 112.590% | 109.843% | 3.651% | 117.505% | 2.31% |

[1] Current increases for 2003-2025 divided by the prior increases for 2003-2024.

Table I-2 below provides the change in the FFS United States Per Capita Cost (USPCC), which was used in the development of the county benchmarks. The percentage change in the FFS USPCC is shown as the current projected FFS USPCC for CY 2025 divided by projected FFS USPCC for CY 2024 as estimated in the CY 2024 Rate Announcement released on March 31, 2023.

**Table I-2. FFS USPCC Growth Percentage for CY 2025**

| | *Aged + Disabled* | *Dialysis–only ESRD* |
|---|---|---|
| Current projected 2025 FFS USPCC | $1,130.85 | $9,713.00 |
| Prior projected 2024 FFS USPCC | 1,105.10 | 9,544.97 |
| Percent change | 2.33% | 1.76% |

Table I-3 below shows the monthly actuarial value of the Medicare deductible and coinsurance for CYs 2024 and 2025. In addition, for CY 2025, the actuarial value of deductibles and coinsurance is being shown for non-ESRD only, since MA plan bids for CY 2025 exclude costs for ESRD enrollees. These data were furnished by the Office of the Actuary.

**Table I-3. Monthly Actuarial Value of Medicare Deductible and Coinsurance for CYs 2024 and 2025**

| | 2024 | 2025 | Change | 2025 non-ESRD |
|---|---|---|---|---|
| Part A Benefits | $36.62 | $36.68 | 0.2% | $34.71 |
| Part B Benefits[1] | 161.71 | 170.32 | 5.3 | 162.29 |
| Total Medicare | 198.33 | 207.00 | 4.4 | 197.00 |

[1] Includes the amounts for outpatient psychiatric charges.

**Medical Savings Account (MSA) Plans.** The maximum deductible for MSA plans for CY 2025 is $16,350.

**Attachment II. Key Assumptions and Financial Information**

The USPCCs are the basis for the National Per Capita MA Growth Percentage. Below is a table that compares last year's estimates of USPCCs with current estimates for 2003 to 2026. In addition, this table shows the current projections of the USPCCs through 2027. We are also providing a set of tables that summarize many of the key Medicare assumptions used in the calculation of the USPCCs. Most of the tables include information for the years 2003 through 2027.

Most of the tables in this attachment present combined aged and disabled non-ESRD data. The ESRD information presented is for the combined aged-ESRD, disabled-ESRD, and ESRD only.

All of the information provided in this attachment applies to the Medicare Part A and Part B programs. Caution should be employed in the use of this information. It is based upon nationwide averages, and local conditions can differ substantially from conditions nationwide.

None of the data presented here pertain to the Medicare Part D prescription drug benefit.

**Table II-1. Comparison of Current & Previous Estimates of the Total USPCC – non-ESRD**

| | Part A | | Part B | | Part A + Part B | | |
|---|---|---|---|---|---|---|---|
| Calendar year | Current estimate | Last year's estimate | Current estimate | Last year's estimate | Current estimate | Last year's estimate | Ratio |
| 2003 | $296.18 | $296.18 | $247.66 | $247.66 | $543.84 | $543.84 | 1.000 |
| 2004 | 314.08 | 314.08 | 271.06 | 271.06 | 585.14 | 585.14 | 1.000 |
| 2005 | 334.83 | 334.83 | 292.86 | 292.86 | 627.69 | 627.69 | 1.000 |
| 2006 | 345.30 | 345.30 | 313.70 | 313.70 | 659.00 | 659.00 | 1.000 |
| 2007 | 355.44 | 355.44 | 330.68 | 330.68 | 686.12 | 686.12 | 1.000 |
| 2008 | 371.90 | 371.90 | 351.04 | 351.04 | 722.94 | 722.94 | 1.000 |
| 2009 | 383.91 | 383.91 | 367.49 | 367.49 | 751.40 | 751.40 | 1.000 |
| 2010 | 383.93 | 383.93 | 376.34 | 376.34 | 760.27 | 760.27 | 1.000 |
| 2011 | 387.73 | 387.73 | 385.30 | 385.30 | 773.03 | 773.03 | 1.000 |
| 2012 | 377.37 | 377.37 | 391.93 | 391.93 | 769.30 | 769.30 | 1.000 |
| 2013 | 380.03 | 380.03 | 398.72 | 398.72 | 778.75 | 778.75 | 1.000 |
| 2014 | 370.23 | 370.23 | 418.20 | 418.36 | 788.43 | 788.59 | 1.000 |
| 2015 | 373.86 | 373.86 | 434.84 | 435.00 | 808.70 | 808.86 | 1.000 |
| 2016 | 377.61 | 377.62 | 444.05 | 444.28 | 821.66 | 821.90 | 1.000 |
| 2017 | 383.10 | 383.09 | 459.01 | 459.19 | 842.11 | 842.28 | 1.000 |
| 2018 | 388.25 | 388.12 | 492.57 | 489.65 | 880.82 | 877.77 | 1.003 |
| 2019 | 400.79 | 400.79 | 525.05 | 521.89 | 925.84 | 922.68 | 1.003 |

| | Part A | | Part B | | Part A + Part B | | |
|---|---|---|---|---|---|---|---|
| Calendar year | Current estimate | Last year's estimate | Current estimate | Last year's estimate | Current estimate | Last year's estimate | Ratio |
| 2020 | 404.09 | 403.90 | 525.19 | 522.48 | 929.28 | 926.38 | 1.003 |
| 2021 | 410.03 | 409.38 | 572.47 | 569.14 | 982.50 | 978.52 | 1.004 |
| 2022 | 433.89 | 431.47 | 607.46 | 603.83 | 1,041.35 | 1,035.30 | 1.006 |
| 2023 | 449.85 | 459.23 | 657.69 | 658.56 | 1,107.54 | 1,117.79 | 0.991 |
| 2024 | 458.16 | 464.05 | 683.05 | 692.10 | 1,141.21 | 1,156.15 | 0.987 |
| 2025 | 466.52 | 480.98 | 716.36 | 729.01 | 1,182.88 | 1,209.99 | 0.978 |
| 2026 | 479.63 | 496.85 | 760.94 | 772.41 | 1,240.57 | 1,269.26 | 0.977 |
| 2027 | 503.41 | | 809.11 | | 1,312.52 | | |

**Table II-2. Comparison of Current & Previous Estimates of the FFS USPCC – non-ESRD**

| | Part A | | Part B | | Part A + Part B | | |
|---|---|---|---|---|---|---|---|
| Calendar year | Current estimate | Last year's estimate | Current estimate | Last year's estimate | Current estimate | Last year's estimate | Ratio |
| 2010 | $371.20 | $369.60 | $374.30 | $374.30 | $745.50 | $743.90 | 1.002 |
| 2011 | 371.15 | 369.45 | 383.17 | 383.17 | 754.32 | 752.62 | 1.002 |
| 2012 | 356.97 | 355.15 | 390.70 | 390.70 | 747.67 | 745.85 | 1.002 |
| 2013 | 363.75 | 361.78 | 394.49 | 394.49 | 758.24 | 756.27 | 1.003 |
| 2014 | 364.20 | 362.07 | 408.91 | 409.16 | 773.11 | 771.23 | 1.002 |
| 2015 | 369.31 | 366.98 | 427.78 | 428.06 | 797.09 | 795.04 | 1.003 |
| 2016 | 371.51 | 369.00 | 433.28 | 433.62 | 804.79 | 802.62 | 1.003 |
| 2017 | 373.86 | 370.97 | 448.00 | 448.28 | 821.86 | 819.25 | 1.003 |
| 2018 | 378.12 | 374.54 | 479.09 | 474.15 | 857.21 | 848.69 | 1.010 |
| 2019 | 383.83 | 380.01 | 506.20 | 500.82 | 890.03 | 880.83 | 1.010 |
| 2020 | 375.84 | 370.93 | 478.49 | 473.65 | 854.33 | 844.58 | 1.012 |
| 2021 | 390.92 | 384.05 | 557.20 | 550.73 | 948.12 | 934.78 | 1.014 |
| 2022 | 407.73 | 398.10 | 578.70 | 573.64 | 986.43 | 971.74 | 1.015 |
| 2023 | 419.82 | 428.63 | 628.51 | 629.07 | 1,048.33 | 1,057.70 | 0.991 |
| 2024 | 431.23 | 440.70 | 654.25 | 664.40 | 1,085.48 | 1,105.10 | 0.982 |
| 2025 | 441.68 | 451.09 | 689.17 | 698.89 | 1,130.85 | 1,149.98 | 0.983 |
| 2026 | 446.80 | 459.88 | 731.88 | 739.42 | 1,178.68 | 1,199.30 | 0.983 |
| 2027 | 468.46 | | 777.17 | | 1,245.63 | | |

**Table II-3. Comparison of Current & Previous Estimates of the ESRD Dialysis-only FFS USPCC**

| | Part A | | Part B | | Part A + Part B | | |
|---|---|---|---|---|---|---|---|
| Calendar year | Current estimate | Last year's estimate | Current estimate | Last year's estimate | Current estimate | Last year's estimate | Ratio |
| 2010 | $2,952.75 | $2,952.75 | $3,881.39 | $3,881.39 | $6,834.14 | $6,834.14 | 1.000 |
| 2011 | 2,862.38 | 2,862.38 | 3,908.01 | 3,908.01 | 6,770.39 | 6,770.39 | 1.000 |
| 2012 | 2,774.49 | 2,774.49 | 3,944.59 | 3,944.59 | 6,719.08 | 6,719.08 | 1.000 |
| 2013 | 2,794.19 | 2,794.19 | 4,088.66 | 4,088.66 | 6,882.85 | 6,882.85 | 1.000 |
| 2014 | 2,784.52 | 2,784.52 | 4,115.70 | 4,115.70 | 6,900.22 | 6,900.22 | 1.000 |
| 2015 | 2,775.84 | 2,775.84 | 4,060.87 | 4,060.87 | 6,836.71 | 6,836.71 | 1.000 |
| 2016 | 2,895.91 | 2,895.91 | 4,081.27 | 4,081.27 | 6,977.18 | 6,977.18 | 1.000 |
| 2017 | 2,883.27 | 2,883.27 | 4,102.66 | 4,102.66 | 6,985.93 | 6,985.93 | 1.000 |
| 2018 | 2,952.21 | 2,952.21 | 4,526.09 | 4,526.09 | 7,478.30 | 7,478.30 | 1.000 |
| 2019 | 3,040.74 | 3,040.74 | 4,614.18 | 4,614.18 | 7,654.92 | 7,654.92 | 1.000 |
| 2020 | 3,082.55 | 3,082.55 | 4,542.51 | 4,542.51 | 7,625.06 | 7,625.06 | 1.000 |
| 2021 | 3,295.54 | 3,295.54 | 4,786.27 | 4,786.27 | 8,081.81 | 8,081.81 | 1.000 |
| 2022 | 3,428.51 | 3,395.47 | 4,834.89 | 4,863.56 | 8,263.40 | 8,259.03 | 1.001 |
| 2023 | 3,576.05 | 3,632.99 | 5,146.20 | 5,296.62 | 8,722.25 | 8,929.61 | 0.977 |
| 2024 | 3,799.72 | 3,835.56 | 5,259.82 | 5,709.41 | 9,059.54 | 9,544.97 | 0.949 |
| 2025 | 3,999.61 | 4,084.94 | 5,713.39 | 6,778.51 | 9,713.00 | 10,863.45 | 0.894 |
| 2026 | 4,254.81 | 4,347.69 | 5,986.57 | 7,309.00 | 10,241.38 | 11,656.69 | 0.879 |
| 2027 | 4,519.44 | | 6,279.35 | | 10,798.79 | | |

## Table II-4. Basis for ESRD Dialysis-only FFS USPCC Trend

| Calendar year | Part A | | | Part B | | | Part A & Part B | | |
|---|---|---|---|---|---|---|---|---|---|
| | All ESRD cumulative FFS trend | Adjustment factor for dialysis-only | Adjusted dialysis-only cumulative trend | All ESRD cumulative FFS trend | Adjustment factor for dialysis-only | Adjusted dialysis-only cumulative trend | All ESRD cumulative FFS trend | Adjustment factor for dialysis-only | Adjusted dialysis-only cumulative trend |
| 2023 | 1.03432 | 1.00842 | 1.04303 | 1.06117 | 1.00303 | 1.06439 | 1.05003 | 1.00523 | 1.05553 |
| 2024 | 1.08983 | 1.01692 | 1.10827 | 1.08132 | 1.00607 | 1.08789 | 1.08485 | 1.01059 | 1.09635 |
| 2025 | 1.13758 | 1.02549 | 1.16657 | 1.12310 | 1.00912 | 1.13334 | 1.12911 | 1.01596 | 1.14713 |
| 2026 | 1.20005 | 1.03413 | 1.24101 | 1.17339 | 1.01218 | 1.18768 | 1.18445 | 1.02141 | 1.20981 |
| 2027 | 1.26403 | 1.04285 | 1.31819 | 1.22721 | 1.01524 | 1.24592 | 1.24249 | 1.02689 | 1.27591 |

## Table II-5. Summary of Key Projections

Part A[1]

| Year | Calendar year CPI percent change | Fiscal year (FY) inpatient PPS update factor | FY Part A total reimbursement (incurred) |
|---|---|---|---|
| 2003 | 1.4% | 3.0% | 3.5% |
| 2004 | 2.1 | 3.4 | 8.4 |
| 2005 | 2.7 | 3.3 | 8.8 |
| 2006 | 4.1 | 3.7 | 5.9 |
| 2007 | 3.3 | 3.4 | 5.7 |
| 2008 | 2.3 | 2.7 | 7.6 |
| 2009 | 5.8 | 2.7 | 6.7 |
| 2010 | 0.0 | 1.9 | 3.0 |
| 2011 | 0.0 | −0.6 | 4.5 |
| 2012 | 3.6 | −0.1 | 0.4 |
| 2013 | 1.7 | 2.8 | 4.7 |
| 2014 | 1.5 | 0.9 | 0.6 |
| 2015 | 1.7 | 1.4 | 3.2 |
| 2016 | 0.0 | 0.9 | 4.3 |
| 2017 | 0.3 | 0.2 | 4.0 |
| 2018 | 2.0 | 1.8 | 4.0 |
| 2019 | 2.8 | 1.9 | 5.5 |
| 2020 | 1.6 | 3.1 | 3.2 |
| 2021 | 1.3 | 2.9 | 5.0 |
| 2022 | 5.9 | 2.5 | 5.1 |
| 2023 | 8.7 | 4.3 | 6.6 |
| 2024 | 3.2 | 3.1 | 4.9 |
| 2025 | 2.6 | 2.6 | 4.3 |
| 2026 | 2.2 | 3.2 | 5.5 |
| 2027 | 2.4 | 3.2 | 3.5 |

Part B[2]

| Calendar year | Physician fee schedule: Fees[3] | Physician fee schedule: Residual[4] | Outpatient hospital | ESRD dialysis update factor[5] | Total |
|---|---|---|---|---|---|
| 2003 | 1.4% | 4.5% | 4.4% | | 6.8% |
| 2004 | 3.8 | 5.9 | 11.1 | | 9.8 |
| 2005 | 2.1 | 3.2 | 10.8 | | 7.0 |
| 2006 | 0.2 | 4.6 | 5.1 | | 6.1 |
| 2007 | -1.4 | 3.5 | 8.2 | | 4.3 |
| 2008 | -0.3 | 4.0 | 6.3 | | 4.8 |
| 2009 | 1.4 | 2.3 | 5.4 | | 3.9 |
| 2010 | 2.3 | 2.1 | 6.6 | | 2.4 |
| 2011 | 0.8 | 2.3 | 7.1 | 2.5% | 2.3 |
| 2012 | -1.2 | 0.8 | 7.2 | 2.1 | 1.7 |
| 2013 | -0.1 | 0.2 | 7.2 | 2.3 | 0.8 |
| 2014 | 0.4 | 0.6 | 12.6 | 2.8 | 3.4 |
| 2015 | -0.3 | -0.3 | 7.4 | 0.0 | 2.7 |
| 2016 | -0.4 | -0.3 | 5.2 | 0.15 | 1.9 |
| 2017 | 0.1 | 1.1 | 7.4 | 0.55 | 2.8 |
| 2018 | 0.5 | 1.1 | 11.4 | 0.3 | 6.2 |
| 2019 | 1.2 | 2.7 | 5.2 | 1.3 | 5.8 |
| 2020 | 0.2 | -11.5 | -5.6 | 1.7 | -1.3 |
| 2021 | 4.8 | 13.1 | 19.8 | 1.6 | 8.7 |
| 2022 | -1.1 | 5.0 | 4.3 | 1.9 | 5.5 |
| 2023 | -0.5 | 3.1 | 9.1 | 3.0 | 6.6 |
| 2024 | -1.6 | 3.6 | 8.3 | 2.1 | 3.2 |
| 2025 | -2.0 | 3.2 | 7.9 | 1.7 | 4.7 |
| 2026 | 0.4 | 2.5 | 8.1 | 2.3 | 5.9 |
| 2027 | 0.4 | 3.3 | 8.4 | 2.3 | 6.1 |

[1] Percent change over prior year.

[2] Percent change in charges per aged Part B enrollee.

[3] Reflects the physician update and legislation affecting physician services—for example, the addition of new preventive services enacted in 1997, 2000, and 2010.

[4] Residual factors are factors other than price, including volume of services, intensity of services, and age/sex changes.

[5] The ESRD Prospective Payment System was implemented in 2011.

## Table II-6. Medicare Enrollment Projections (In millions)

non-ESRD Total

| | Part A | | Part B | |
|---|---|---|---|---|
| Calendar year | Aged | Disabled | Aged | Disabled |
| 2003 | 34.437 | 5.961 | 33.038 | 5.215 |
| 2004 | 34.849 | 6.283 | 33.294 | 5.486 |
| 2005 | 35.257 | 6.610 | 33.621 | 5.776 |
| 2006 | 35.795 | 6.889 | 33.975 | 6.017 |
| 2007 | 36.447 | 7.167 | 34.465 | 6.245 |
| 2008 | 37.378 | 7.362 | 35.140 | 6.438 |
| 2009 | 38.257 | 7.574 | 35.832 | 6.664 |
| 2010 | 39.091 | 7.832 | 36.516 | 6.938 |
| 2011 | 39.950 | 8.171 | 37.247 | 7.254 |
| 2012 | 41.687 | 8.411 | 38.546 | 7.502 |
| 2013 | 43.087 | 8.629 | 39.779 | 7.732 |
| 2014 | 44.533 | 8.776 | 41.063 | 7.894 |
| 2015 | 45.911 | 8.853 | 42.311 | 7.977 |
| 2016 | 47.370 | 8.862 | 43.623 | 7.990 |
| 2017 | 48.893 | 8.940 | 44.944 | 8.007 |
| 2018 | 50.457 | 8.696 | 46.310 | 7.861 |
| 2019 | 52.119 | 8.530 | 47.765 | 7.735 |
| 2020 | 53.683 | 8.318 | 49.224 | 7.572 |
| 2021 | 55.040 | 8.069 | 50.517 | 7.361 |
| 2022 | 56.531 | 7.746 | 51.883 | 7.097 |
| 2023 | 58.423 | 7.394 | 53.503 | 6.819 |
| 2024 | 60.074 | 7.056 | 55.085 | 6.482 |
| 2025 | 61.747 | 6.845 | 56.696 | 6.296 |
| 2026 | 63.463 | 6.845 | 58.333 | 6.295 |
| 2027 | 65.040 | 6.936 | 59.875 | 6.379 |

non-ESRD FFS

| | Part A | | Part B | |
|---|---|---|---|---|
| Calendar year | Aged | Disabled | Aged | Disabled |
| 2003 | 29.593 | 5.628 | 28.097 | 4.875 |
| 2004 | 29.946 | 5.931 | 28.300 | 5.128 |
| 2005 | 30.014 | 6.178 | 28.287 | 5.339 |
| 2006 | 29.362 | 6.149 | 27.459 | 5.270 |
| 2007 | 28.838 | 6.225 | 26.782 | 5.297 |
| 2008 | 28.613 | 6.241 | 26.301 | 5.311 |
| 2009 | 28.563 | 6.288 | 26.071 | 5.374 |
| 2010 | 28.903 | 6.455 | 26.261 | 5.556 |
| 2011 | 29.210 | 6.659 | 26.440 | 5.736 |
| 2012 | 29.960 | 6.693 | 26.744 | 5.779 |
| 2013 | 30.330 | 6.691 | 26.948 | 5.790 |
| 2014 | 30.603 | 6.618 | 27.060 | 5.732 |
| 2015 | 30.947 | 6.488 | 27.274 | 5.609 |
| 2016 | 31.629 | 6.378 | 27.814 | 5.503 |
| 2017 | 31.916 | 6.299 | 27.882 | 5.361 |
| 2018 | 32.167 | 5.867 | 27.926 | 5.027 |
| 2019 | 32.466 | 5.466 | 28.016 | 4.665 |
| 2020 | 32.220 | 4.952 | 27.665 | 4.201 |

| | Part A | | Part B | |
|---|---|---|---|---|
| Calendar year | Aged | Disabled | Aged | Disabled |
| 2021 | 31.438 | 4.424 | 26.820 | 3.713 |
| 2022 | 30.870 | 3.899 | 26.128 | 3.248 |
| 2023 | 30.616 | 3.396 | 25.573 | 2.789 |
| 2024 | 30.320 | 2.774 | 25.192 | 2.184 |
| 2025 | 30.429 | 2.283 | 25.255 | 1.724 |
| 2026 | 30.894 | 2.139 | 25.647 | 1.583 |
| 2027 | 31.249 | 2.063 | 25.967 | 1.500 |

ESRD

| | ESRD - Total | | ESRD - FFS | |
|---|---|---|---|---|
| Calendar year | Total Part A | Total Part B | Total Part A | Total Part B |
| 2003 | 0.340 | 0.331 | 0.319 | 0.309 |
| 2004 | 0.353 | 0.342 | 0.332 | 0.321 |
| 2005 | 0.366 | 0.355 | 0.344 | 0.332 |
| 2006 | 0.382 | 0.370 | 0.353 | 0.340 |
| 2007 | 0.396 | 0.383 | 0.361 | 0.347 |
| 2008 | 0.411 | 0.397 | 0.367 | 0.353 |
| 2009 | 0.426 | 0.412 | 0.374 | 0.360 |
| 2010 | 0.442 | 0.428 | 0.388 | 0.373 |
| 2011 | 0.429 | 0.416 | 0.371 | 0.358 |
| 2012 | 0.441 | 0.429 | 0.379 | 0.366 |
| 2013 | 0.454 | 0.441 | 0.385 | 0.372 |
| 2014 | 0.469 | 0.456 | 0.390 | 0.377 |
| 2015 | 0.482 | 0.468 | 0.393 | 0.379 |
| 2016 | 0.496 | 0.481 | 0.400 | 0.384 |
| 2017 | 0.511 | 0.495 | 0.404 | 0.386 |
| 2018 | 0.525 | 0.507 | 0.405 | 0.387 |
| 2019 | 0.538 | 0.520 | 0.407 | 0.388 |
| 2020 | 0.542 | 0.524 | 0.398 | 0.379 |
| 2021 | 0.533 | 0.515 | 0.331 | 0.312 |
| 2022 | 0.528 | 0.509 | 0.292 | 0.273 |
| 2023 | 0.525 | 0.509 | 0.257 | 0.239 |
| 2024 | 0.531 | 0.517 | 0.234 | 0.219 |
| 2025 | 0.542 | 0.526 | 0.230 | 0.213 |
| 2026 | 0.555 | 0.539 | 0.232 | 0.216 |
| 2027 | 0.568 | 0.552 | 0.235 | 0.219 |

## Table II-7a. Part A Projections for non-ESRD (Aged+Disabled)*

| Calendar year | Inpatient hospital | SNF | Home health agency | Managed care | Hospice: Total reimbursement (in millions) |
|---|---|---|---|---|---|
| 2003 | $2,594.78 | $370.63 | $124.28 | $457.87 | $5,733 |
| 2004 | 2,714.57 | 413.44 | 133.89 | 500.73 | 6,832 |
| 2005 | 2,818.21 | 450.54 | 140.87 | 602.29 | 8,016 |
| 2006 | 2,764.82 | 475.07 | 141.30 | 757.25 | 9,368 |
| 2007 | 2,707.49 | 504.24 | 143.72 | 905.73 | 10,518 |
| 2008 | 2,695.88 | 536.68 | 151.00 | 1,074.98 | 11,404 |
| 2009 | 2,651.47 | 551.67 | 153.86 | 1,246.01 | 12,274 |
| 2010 | 2,627.03 | 571.74 | 155.18 | 1,249.70 | 13,126 |
| 2011 | 2,585.95 | 623.31 | 138.31 | 1,299.28 | 13,897 |
| 2012 | 2,489.44 | 541.69 | 130.82 | 1,360.09 | 15,068 |
| 2013 | 2,485.37 | 540.47 | 128.47 | 1,399.68 | 15,263 |
| 2014 | 2,424.11 | 534.33 | 123.88 | 1,354.21 | 15,346 |
| 2015 | 2,407.71 | 530.93 | 126.06 | 1,416.03 | 16,159 |
| 2016 | 2,425.80 | 504.76 | 121.43 | 1,475.44 | 17,128 |
| 2017 | 2,404.74 | 484.60 | 117.33 | 1,586.71 | 18,228 |
| 2018 | 2,380.36 | 465.54 | 113.86 | 1,695.37 | 19,561 |
| 2019 | 2,343.50 | 444.25 | 108.46 | 1,909.92 | 21,168 |
| 2020 | 2,172.07 | 450.95 | 95.45 | 2,127.61 | 22,308 |
| 2021 | 2,165.19 | 420.89 | 93.06 | 2,238.30 | 22,997 |
| 2022 | 2,121.71 | 448.07 | 90.38 | 2,543.48 | 24,162 |
| 2023 | 2,111.02 | 418.61 | 87.52 | 2,777.98 | 26,268 |
| 2024 | 2,069.07 | 404.68 | 89.50 | 2,931.52 | 27,950 |
| 2025 | 2,028.60 | 418.43 | 92.63 | 3,055.93 | 29,922 |
| 2026 | 1,989.92 | 439.46 | 101.58 | 3,221.23 | 32,555 |
| 2027 | 2,044.15 | 461.75 | 107.99 | 3,423.54 | 35,613 |

*Average annual reimbursement per enrollee on an incurred basis.

## Table II-7b. Part A Projections for non-ESRD (Aged+Disabled)*

| Calendar year | Inpatient hospital | SNF | Home health agency | Managed care |
|---|---|---|---|---|
| 2003 | $248.02 | $35.43 | $11.88 | $297.71 |
| 2004 | 259.34 | 39.50 | 12.79 | 326.66 |
| 2005 | 271.67 | 43.43 | 13.58 | 370.30 |
| 2006 | 276.94 | 47.59 | 14.15 | 375.52 |
| 2007 | 280.65 | 52.27 | 14.90 | 384.98 |
| 2008 | 288.38 | 57.41 | 16.15 | 405.41 |
| 2009 | 290.56 | 60.45 | 16.86 | 433.45 |
| 2010 | 290.52 | 63.23 | 17.16 | 422.53 |
| 2011 | 286.48 | 69.05 | 15.34 | 435.96 |
| 2012 | 280.78 | 61.05 | 14.78 | 432.55 |
| 2013 | 286.35 | 62.22 | 14.82 | 420.62 |
| 2014 | 286.17 | 63.03 | 14.64 | 383.80 |
| 2015 | 289.86 | 63.89 | 15.21 | 383.32 |
| 2016 | 295.04 | 61.35 | 14.80 | 389.99 |
| 2017 | 298.76 | 60.17 | 14.61 | 400.77 |
| 2018 | 303.85 | 59.39 | 14.56 | 406.16 |
| 2019 | 310.41 | 58.77 | 14.38 | 428.81 |
| 2020 | 300.17 | 62.24 | 13.20 | 446.10 |
| 2021 | 315.67 | 61.26 | 13.58 | 435.15 |
| 2022 | 324.88 | 68.54 | 13.86 | 464.69 |
| 2023 | 338.33 | 66.99 | 14.04 | 481.93 |
| 2024 | 347.78 | 67.92 | 15.06 | 484.29 |
| 2025 | 352.45 | 72.62 | 16.12 | 489.19 |
| 2026 | 350.91 | 77.45 | 17.95 | 510.09 |
| 2027 | 365.95 | 82.62 | 19.37 | 533.42 |

*Average monthly reimbursement per enrollee on an incurred basis. Excludes cost plan expenditures included in National Claims History file. Denominator for all fields except Managed Care is Part A FFS enrollment. Denominator for Managed Care field is Part C enrollment.

## Table II-8a. Part B Projections for non-ESRD (Aged+Disabled)*

| Calendar year | Physician fee schedule | Outpatient hospital | Durable medical equipment |
|---|---|---|---|
| 2003 | $1,226.51 | $364.77 | $196.96 |
| 2004 | 1,344.01 | 418.85 | 195.61 |
| 2005 | 1,397.43 | 477.65 | 196.83 |
| 2006 | 1,396.40 | 497.47 | 197.78 |
| 2007 | 1,368.35 | 526.92 | 195.68 |
| 2008 | 1,367.83 | 555.09 | 200.92 |
| 2009 | 1,386.03 | 587.61 | 183.61 |
| 2010 | 1,429.74 | 623.13 | 183.76 |
| 2011 | 1,459.64 | 662.97 | 175.84 |
| 2012 | 1,412.72 | 697.86 | 173.70 |
| 2013 | 1,369.64 | 735.33 | 152.53 |
| 2014 | 1,351.36 | 821.29 | 128.57 |
| 2015 | 1,336.28 | 873.84 | 132.77 |
| 2016 | 1,313.76 | 908.35 | 120.73 |
| 2017 | 1,294.45 | 949.82 | 112.30 |
| 2018 | 1,287.56 | 1,033.92 | 127.05 |
| 2019 | 1,303.15 | 1,054.17 | 128.93 |
| 2020 | 1,110.27 | 948.78 | 123.23 |
| 2021 | 1,256.75 | 1,069.49 | 121.19 |
| 2022 | 1,209.84 | 1,023.29 | 130.33 |
| 2023 | 1,186.41 | 1,073.74 | 151.31 |
| 2024 | 1,143.44 | 1,103.67 | 144.15 |
| 2025 | 1,116.01 | 1,149.36 | 143.82 |
| 2026 | 1,127.23 | 1,224.04 | 149.87 |
| 2027 | 1,146.02 | 1,306.62 | 155.29 |

| Calendar year | Carrier lab | Physician administered drugs | Other carrier | Intermediary lab |
|---|---|---|---|---|
| 2003 | $73.73 | $182.58 | $147.21 | $75.18 |
| 2004 | 78.48 | 195.20 | 158.78 | 80.47 |
| 2005 | 82.71 | 178.77 | 184.02 | 84.16 |
| 2006 | 85.59 | 185.41 | 175.66 | 84.51 |
| 2007 | 90.65 | 186.97 | 176.55 | 84.38 |
| 2008 | 94.50 | 184.43 | 182.19 | 85.78 |
| 2009 | 101.60 | 196.19 | 178.46 | 79.19 |
| 2010 | 103.81 | 196.41 | 178.67 | 80.23 |
| 2011 | 103.85 | 209.50 | 179.44 | 83.31 |
| 2012 | 111.73 | 209.34 | 185.17 | 84.64 |
| 2013 | 111.79 | 216.91 | 177.08 | 81.74 |
| 2014 | 117.60 | 224.56 | 173.55 | 55.45 |
| 2015 | 113.99 | 252.11 | 174.94 | 55.26 |
| 2016 | 100.91 | 271.45 | 172.90 | 56.21 |
| 2017 | 100.65 | 280.51 | 177.43 | 54.99 |
| 2018 | 107.29 | 304.36 | 176.15 | 52.94 |
| 2019 | 108.74 | 329.29 | 174.11 | 50.30 |
| 2020 | 109.14 | 325.00 | 166.32 | 51.75 |
| 2021 | 122.81 | 339.57 | 165.19 | 56.21 |
| 2022 | 111.42 | 361.55 | 191.29 | 51.81 |
| 2023 | 102.43 | 397.67 | 205.78 | 46.37 |
| 2024 | 102.07 | 415.37 | 156.09 | 45.12 |
| 2025 | 103.16 | 443.91 | 154.98 | 44.63 |
| 2026 | 112.40 | 474.79 | 158.24 | 46.53 |
| 2027 | 116.20 | 506.23 | 161.73 | 46.98 |

*Average reimbursement per enrollee on an incurred basis.

| Calendar year | Other intermediary | Home health agency | Managed care |
|---|---|---|---|
| 2003 | $113.99 | $136.75 | $421.40 |
| 2004 | 119.58 | 156.45 | 471.37 |
| 2005 | 139.78 | 179.44 | 560.31 |
| 2006 | 142.09 | 202.88 | 769.94 |
| 2007 | 151.16 | 232.33 | 931.18 |
| 2008 | 158.20 | 252.43 | 1,104.26 |
| 2009 | 187.44 | 282.09 | 1,203.78 |
| 2010 | 193.08 | 283.25 | 1,221.28 |
| 2011 | 198.15 | 254.42 | 1,276.29 |
| 2012 | 205.08 | 239.36 | 1,368.13 |
| 2013 | 194.43 | 234.07 | 1,497.49 |
| 2014 | 200.51 | 227.73 | 1,703.30 |
| 2015 | 210.36 | 224.84 | 1,829.45 |
| 2016 | 214.18 | 219.09 | 1,938.57 |
| 2017 | 220.57 | 208.93 | 2,096.91 |
| 2018 | 228.23 | 206.53 | 2,375.34 |
| 2019 | 235.82 | 201.42 | 2,704.30 |
| 2020 | 208.37 | 187.29 | 3,062.48 |
| 2021 | 219.60 | 182.57 | 3,326.73 |
| 2022 | 212.61 | 173.40 | 3,814.42 |
| 2023 | 220.49 | 168.95 | 4,328.66 |
| 2024 | 218.70 | 168.28 | 4,688.83 |
| 2025 | 221.37 | 170.75 | 5,036.97 |
| 2026 | 229.72 | 183.83 | 5,412.57 |
| 2027 | 238.28 | 195.13 | 5,823.94 |

* Average annual reimbursement per enrollee on an incurred basis.

**Table II-8b. Part B Projections for non-ESRD (Aged+Disabled)***

| Calendar year | Physician fee schedule | Outpatient hospital | Durable medical equipment |
|---|---|---|---|
| 2003 | $118.58 | $35.27 | $19.04 |
| 2004 | 129.94 | 40.49 | 18.91 |
| 2005 | 136.44 | 46.64 | 19.22 |
| 2006 | 142.19 | 50.65 | 20.14 |
| 2007 | 144.71 | 55.72 | 20.69 |
| 2008 | 149.92 | 60.84 | 22.02 |
| 2009 | 156.10 | 66.18 | 20.68 |
| 2010 | 162.73 | 70.92 | 20.91 |
| 2011 | 167.79 | 74.91 | 20.27 |
| 2012 | 166.32 | 80.61 | 20.36 |
| 2013 | 165.24 | 87.00 | 18.29 |
| 2014 | 167.65 | 99.96 | 15.82 |
| 2015 | 169.74 | 108.75 | 16.72 |
| 2016 | 169.02 | 114.38 | 15.35 |
| 2017 | 171.21 | 122.79 | 14.65 |
| 2018 | 175.76 | 138.01 | 17.13 |
| 2019 | 184.30 | 147.54 | 17.94 |
| 2020 | 164.63 | 139.34 | 18.18 |
| 2021 | 198.20 | 166.96 | 19.03 |
| 2022 | 201.98 | 168.97 | 21.69 |
| 2023 | 209.88 | 187.79 | 26.70 |
| 2024 | 213.91 | 204.39 | 26.88 |
| 2025 | 216.74 | 221.05 | 27.86 |
| 2026 | 222.51 | 239.37 | 29.51 |
| 2027 | 230.04 | 259.78 | 31.07 |

| Calendar year | Carrier lab | Physician administered drugs | Other carrier | Intermediary lab |
|---|---|---|---|---|
| 2003 | $7.13 | $17.65 | $14.23 | $7.27 |
| 2004 | 7.59 | 18.87 | 15.35 | 7.78 |
| 2005 | 8.08 | 17.45 | 17.97 | 8.22 |
| 2006 | 8.72 | 18.88 | 17.89 | 8.60 |
| 2007 | 9.59 | 19.77 | 18.67 | 8.92 |
| 2008 | 10.36 | 20.22 | 19.97 | 9.40 |
| 2009 | 11.44 | 22.10 | 20.10 | 8.92 |
| 2010 | 11.82 | 22.35 | 20.34 | 9.13 |
| 2011 | 11.97 | 24.15 | 20.68 | 9.60 |
| 2012 | 13.18 | 24.70 | 21.85 | 9.99 |
| 2013 | 13.52 | 26.23 | 21.42 | 9.89 |
| 2014 | 14.63 | 27.94 | 21.59 | 6.90 |
| 2015 | 14.53 | 32.13 | 22.29 | 7.04 |
| 2016 | 13.03 | 35.04 | 22.32 | 7.26 |
| 2017 | 13.36 | 37.23 | 23.55 | 7.30 |
| 2018 | 14.70 | 41.69 | 24.13 | 7.25 |
| 2019 | 15.39 | 46.60 | 24.64 | 7.12 |
| 2020 | 16.21 | 48.27 | 24.70 | 7.69 |
| 2021 | 19.40 | 53.64 | 26.09 | 8.88 |
| 2022 | 18.64 | 60.49 | 32.01 | 8.67 |
| 2023 | 18.15 | 70.49 | 36.47 | 8.22 |
| 2024 | 19.13 | 77.84 | 29.25 | 8.46 |
| 2025 | 20.07 | 86.37 | 30.15 | 8.68 |
| 2026 | 22.23 | 93.90 | 31.30 | 9.20 |
| 2027 | 23.36 | 101.76 | 32.51 | 9.44 |

*Average monthly reimbursement per enrollee on an incurred basis. Excludes cost plan expenditures included in National Claims History file. Denominator for all fields except Managed Care is Part A FFS enrollment. Denominator for Managed Care field is Part C enrollment.

| Calendar year | Other intermediary | Home health agency | Managed care |
|---|---|---|---|
| 2003 | $11.02 | $13.22 | $254.39 |
| 2004 | 11.56 | 15.12 | 284.58 |
| 2005 | 13.65 | 17.52 | 318.75 |
| 2006 | 14.47 | 20.66 | 353.34 |
| 2007 | 15.99 | 24.57 | 366.01 |
| 2008 | 17.34 | 27.67 | 383.90 |
| 2009 | 21.11 | 31.77 | 385.73 |
| 2010 | 21.98 | 32.24 | 380.01 |
| 2011 | 22.84 | 29.29 | 389.17 |
| 2012 | 24.20 | 28.21 | 393.60 |
| 2013 | 23.51 | 28.27 | 406.92 |
| 2014 | 24.95 | 28.29 | 435.78 |
| 2015 | 26.81 | 28.60 | 446.95 |
| 2016 | 27.65 | 28.22 | 462.58 |
| 2017 | 29.28 | 27.68 | 476.58 |
| 2018 | 31.26 | 28.23 | 512.52 |
| 2019 | 33.37 | 28.47 | 551.14 |
| 2020 | 30.95 | 27.79 | 583.99 |
| 2021 | 34.69 | 28.81 | 589.52 |
| 2022 | 35.57 | 28.98 | 636.01 |
| 2023 | 39.08 | 29.91 | 683.56 |
| 2024 | 40.98 | 31.50 | 706.00 |
| 2025 | 43.07 | 33.18 | 736.57 |
| 2026 | 45.43 | 36.31 | 781.91 |
| 2027 | 47.90 | 39.18 | 831.49 |

* Average reimbursement per enrollee on an incurred basis.

**Table II-9. 2025 Projections by Service Category for non-ESRD (Aged+Disabled)***

| Service type | Current estimate | Last year's estimate | Ratio |
|---|---|---|---|
| Part A | | | |
| Inpatient hospital | $2,028.60 | $2,122.61 | 0.956 |
| SNF | 418.43 | 434.96 | 0.962 |
| Home health agency | 92.63 | 102.09 | 0.907 |
| Managed care | 3,055.93 | 3,108.74 | 0.983 |
| Part B | | | |
| Physician fee schedule | 1,116.01 | 1,139.05 | 0.980 |
| Outpatient hospital | 1,149.36 | 1,266.88 | 0.907 |
| Durable medical equipment | 143.82 | 138.33 | 1.040 |
| Carrier lab | 103.16 | 128.70 | 0.802 |
| Physician Administered Drugs | 443.91 | 410.19 | 1.082 |
| Other carrier | 154.98 | 187.50 | 0.827 |
| Intermediary lab | 44.63 | 54.52 | 0.819 |
| Other intermediary | 221.37 | 221.29 | 1.000 |
| Home health agency | 170.75 | 182.19 | 0.937 |
| Managed care | 5,036.97 | 5,007.97 | 1.006 |

* Average reimbursement per enrollee on an incurred basis.

**Table II-10. Claims Processing Costs as a Fraction of Benefits**

| Calendar year | FFS Part A | FFS Part B | Total Part A | Total Part B |
|---|---|---|---|---|
| 2003 | 0.001849 | 0.011194 | 0.001849 | 0.011194 |
| 2004 | 0.001676 | 0.010542 | 0.001676 | 0.010542 |
| 2005 | 0.001515 | 0.009540 | 0.001515 | 0.009540 |
| 2006 | 0.001245 | 0.007126 | 0.001245 | 0.007126 |
| 2007 | 0.000968 | 0.006067 | 0.000968 | 0.006067 |
| 2008 | 0.000944 | 0.006414 | 0.000944 | 0.006414 |
| 2009 | 0.000844 | 0.005455 | 0.000844 | 0.005455 |
| 2010 | 0.000773 | 0.005055 | 0.000773 | 0.005055 |
| 2011 | 0.000749 | 0.004396 | 0.000749 | 0.004396 |
| 2012 | 0.001008 | 0.003288 | 0.001008 | 0.003288 |
| 2013 | 0.000994 | 0.002846 | 0.000994 | 0.002846 |
| 2014 | 0.001003 | 0.002884 | 0.001003 | 0.002884 |
| 2015 | 0.000952 | 0.002730 | 0.000952 | 0.002730 |
| 2016 | 0.000852 | 0.002348 | 0.000852 | 0.002348 |
| 2017 | 0.000833 | 0.002111 | 0.000833 | 0.002111 |
| 2018 | 0.000836 | 0.001953 | 0.000836 | 0.001953 |
| 2019 | 0.000699 | 0.001644 | 0.000699 | 0.001644 |
| 2020 | 0.000625 | 0.001536 | 0.000625 | 0.001536 |
| 2021 | 0.001038 | 0.002708 | 0.000600 | 0.001399 |
| 2022 | 0.001094 | 0.002801 | 0.000582 | 0.001310 |
| 2023 | 0.001102 | 0.002916 | 0.000579 | 0.001330 |
| 2024 | 0.001102 | 0.002916 | 0.000579 | 0.001330 |
| 2025 | 0.001102 | 0.002916 | 0.000579 | 0.001330 |
| 2026 | 0.001102 | 0.002916 | 0.000579 | 0.001330 |
| 2027 | 0.001102 | 0.002916 | 0.000579 | 0.001330 |

**Approximate Calculation of the USPCC, the National MA Growth Percentage for Combined (Aged+Disabled) Beneficiaries, and the FFS USPCC (Aged+Disabled)**

The following procedure will approximate the actual calculation of the USPCCs from the underlying assumptions for the contract year for both Part A and Part B.

Part A: The Part A USPCC can be approximated by using the assumptions in the tables titled "Part A Projections for non-ESRD (Aged+Disabled)" and "Claims Processing Costs as a Fraction of Benefits." Information in the "Part A Projections" table is presented on a calendar year per capita basis. First, add the per capita amounts over all types of providers (excluding hospice). Next, multiply this amount by 1 plus the loading factor for administrative expenses from the "Claims Processing Costs" table. Then, divide by 12 to put this amount on a monthly basis.

Part B: The Part B USPCC can be approximated by using the assumptions in the tables titled "Part B Projections for non-ESRD (Aged+Disabled)" and "Claims Processing Costs as a Fraction of Benefits." Information in the "Part B Projections" table is presented on a calendar year per capita basis. First, add the per capita amounts over all types of providers. Next, multiply by 1 plus the loading factor for administrative expenses from the "Claims Processing Costs" table and then divide by 12 to put this amount on a monthly basis.

The National Per Capita MA Growth Percentage: The National Per Capita MA Growth Percentage for CY 2025 (before adjusting for prior years' over/under estimates) is calculated by adding the USPCCs for Part A and Part B for CY 2025 and then dividing by the sum of the current estimates of the USPCCs for Part A and Part B for 2024.

The FFS USPCC: The tables used to calculate the total USPCC can also be used to approximate the calculation of the FFS USPCC. The per capita data presented by type of provider in the projection tables for both Part A and Part B are based on total enrollment. To approximate the FFS USPCCs, first add the corresponding provider types under Part A and Part B separately. For the FFS calculations, do not include the managed care provider type. Next, rebase the sum of the per capita amounts for FFS enrollees, i.e., multiply the sum by total enrollees and divide by FFS enrollees. (The enrollment tables in this attachment now also include FFS enrollment). Then, multiply by 1 plus the loading factor for administrative expenses and divide by 12. The result will only be approximate because there is an additional adjustment to the FFS data which accounts for cost plan data which comes through the FFS data system. This cost plan data is in the total per capita amounts by type of provider, but it is removed for the FFS calculations.

## Attachment III. Responses to Public Comments on Part C Payment Policy

### Section A. General Comments

Comment: CMS received a large number of comments in response to the CY 2025 Advance Notice, with many supporting the direction of the proposals in the Advance Notice and others expressing concerns about the impacts of the proposed updates. Commenters who supported the proposals in the Advance Notice believed that the continuation of the phase-in of the technical adjustment to the growth rates is a much-needed step to ensure payment accuracy and preserve the financial integrity of the Medicare Trust Fund. A few commenters appreciated that the proposals included in the Advance Notice provide stability in the MA and Part D programs, particularly in light of upcoming Part D redesign and other new requirements in the MA and Part D programs. A couple of commenters expressed continued support for the policies established in the CY 2024 Rate Announcement, with one commenter noting that the risk adjustment model finalized for CY 2024 was an important step in reducing overpayments to MA plans, and another writing that the policies established for CY 2024 have not negatively impacted plan availability or choice. Additionally, several comments expressed general support for MA, highlighting the success of the MA program and the value the program brings to enrollees in the form of enhanced benefits and lower cost sharing.

Many of the commenters who did not support the proposed changes included in the Advance Notice saw the net effect of the proposals as cuts to the MA program that may increase costs for beneficiaries and reduce the quality and quantity of benefits currently offered by MA plans and special needs plans (SNPs). Commenters expressed concern that such impacts could differ across geographic markets and patient groups, such as dual eligible enrollees or enrollees with chronic conditions, and decrease the stability of the program. These commenters urged CMS to not implement the proposed updates, with one commenter particularly emphasizing that CMS consider the changes in the context of other upcoming regulatory requirements included in the MA and Part D final rule and related to Pharmacy Direct and Indirect Remuneration (DIR) policy change effective in 2024. A commenter requested that CMS analyze the net effect of the proposed changes on beneficiaries enrolled in SNPs. Additionally, several commenters noted that depressed payment growth rates are not aligned with increasing inflation and can indirectly result in negative impacts to provider payments, potentially stressing the provider workforce and resulting in decreased provider availability. One commenter believed that the level of the payment change included in the CY 2024 Rate Announcement has already resulted in reduced plan availability, beneficiary access, and supplemental benefits offerings. Another commenter, while expressing support for the MA program, requested that CMS monitor how well the MA program serves beneficiaries in terms of spending, benefits, quality, outcomes, and access to providers.

A number of the commenters who did not support the proposals in the CY 2025 Advance Notice expressed concern that the proposed 3.70 percent increase in MA payment was too high and urged CMS to reduce MA rates to a level commensurate with FFS rates. These commenters opposed the estimated $16 billion increase in plan payments and expressed concern that CMS overpays MA plans, citing investigations and reports primarily from the Office of Inspector General (OIG) and the Medicare Payment Advisory Commission (MedPAC). Many of these commenters stated the MA program is negatively impacting Medicare's financial and long-term sustainability and expressed support for increased oversight of the MA plans and for risk adjustment data validation (RADV) audits of MA plans' coding practices to address harmful corporate practices, abuses and gaming, such as upcoding, favorable selection, and prior authorization delays and denials. A commenter stated that MA payments should strike a balance between encouraging insurers to enter and remain in the MA market and providing value for beneficiaries, taxpayers, and Medicare.

Additionally, a few commenters cited a lack of transparency relating to various proposals in the Advance Notice, and a commenter noted that the level of technicality and density of the Advance Notice can deter community-based organizations and Medicare enrollees from commenting.

Response: CMS thanks commenters for their thoughts and input regarding payments made under the MA program. CMS has a fiduciary duty to be a steward of the Medicare program. Protecting and strengthening Medicare for the over 66 million Americans who have it now, and all the beneficiaries in the future, is a key priority for CMS. Core to this mission is to maintain stability for Medicare beneficiaries in both Medicare FFS and MA. The policies finalized for CY 2025 are projected to increase average payments to MA organizations by 3.70 percent in CY 2025, which will provide continued stability to the MA market and MA beneficiaries. As we did for CY 2024, we are finalizing policies that are commonsense, clinically-based technical updates that are crucial to ensuring that payments to MA organizations are up to date and reflect current diagnostic and expenditure trends. The updates included in the CY 2025 Rate Announcement ensure accurate, appropriate payments to MA organizations and prevent wasteful Medicare spending. These policies were proposed and finalized using careful analyses, in alignment with CMS' strategic pillars, especially our commitment to health equity, at the top of mind. Further, we note that MA payments, though different than FFS payments, are closely tied to FFS payment levels and are reflective of market considerations.

We respectfully disagree with those commenters' claims that this continued reasonable update to payments in MA is actually a payment cut that will result in increased costs or fewer benefits for beneficiaries. As a commenter described, despite the fact that the projected 3.32 percent payment change finalized in the CY 2024 Rate Announcement was lower than recent years' rates, plan

availability, choice, enrollment, and benefit offerings remained stable or grew in 2024.[2] For CY 2024, on average, a beneficiary will be able to choose from 43 MA plans, which, in addition to providing stability from CYs 2023 to 2024, represents the highest point of plan availability relative to recently preceding years. Availability of SNPs is also at its highest level historically, with 1,333 plans available nationwide, representing a 4 percent increase from CY 2023. Overall MA enrollment has similarly not been negatively impacted by the projected 3.32 percent payment increase we finalized in the CY 2024 Rate Announcement and has increased by nearly 6 percent from January 2023 to January 2024. As an example, enrollment in Dual-Eligible Special Needs Plans (D-SNPs) grew by nearly 20 percent from January 2023 to January 2024. Further, for CY 2024, 66 percent of MA-PDs charge no plan premium, consistent with CY 2023. And finally, in CY 2024, average rebate payments to plans, which fund supplemental benefits, increased for CY 2024 and at least 97 percent of individual plans offer some form of supplemental benefits. Additionally, 99 percent of Medicare beneficiaries have access to at least one or more plans with dental, fitness, vision, and hearing benefits, and 97 percent of SNPs offer at least some supplemental benefits. CMS also notes that, given the increasing interest in and availability of supplemental benefits, starting with CY 2024 dates of services, MA organizations will be newly required to submit data for supplemental benefits through encounter data reporting. This effort intends to increase transparency around and better document the use and value of supplemental benefits in MA.

Given the stability recorded year-over-year following the changes announced in the CY 2024 Rate Announcement, CMS expects that this year's estimated 3.70 percent increase to similarly provide continued stability in beneficiary access, choice, and benefits. CMS reminds readers that the updates and the continued planned phase-in of the risk adjustment model proposed in the CY 2025 Advance Notice are technical, data-driven, and clinically-based updates that improve the accuracy of payments to MA organizations, as required under the statute governing the MA program. As stated in the CY 2024 Rate Announcement, CMS expects MA organizations to recognize the importance of maintaining stability in the MA program and have strong business plans, long term financial strength, and a sustainable and robust business trajectory.

Finally, CMS recognizes that plan sponsors are facing several different updates to the MA and Part D programs over the next few years and is cognizant of the operational complexity of these changes. CMS is making every effort to provide resources to help stakeholders prepare for upcoming changes to the MA and Part D programs. For example, in September 2023, CMS held a User Group training session focused on CY 2025 Part D risk adjustment model updates, and CMS encourages interested parties to monitor Health Plan Management System (HPMS) memoranda for other training opportunities and informational resources. Additionally, although

[2] Refer to the Medicare Advantage/Part D Contract and Enrollment Data files. See additional analyses of this and other data sources on MA and Part D by the Kaiser Family Foundation.

CMS recognizes that the document is highly technical, given its focus on capitation and payment rates, we invited all interested parties to provide comment on the Advance Notice. We also released a Fact Sheet and FAQs that summarized key proposed updates and the impact of such changes. We also note that CMS did receive many comments from beneficiaries and community-facing organizations.

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

***Phase-in of Technical Adjustment to the non-ESRD USPCC Baseline Regarding MA-Related Medical Education Expenses***

Comment: A commenter expressed appreciation for the phased-in approach to the technical adjustment that began with the CY 2024 MA rates.

Response: We appreciate the support.

Comment: A couple of commenters expressed concern that the continued phase-in of the technical adjustment would reduce the non-ESRD FFS growth rate during a period when MA plans are experiencing higher utilization and cost trends. Many commenters requested that CMS consider pausing the continued phase-in of the technical adjustment for CY 2025, extending the phase-in period (ex: over five years with 40 percent of the technical adjustment for CY 2025), or delaying the continued phase-in until at least 2026 or 2027, in order to further mitigate the impact of the technical adjustment.

A couple of commenters expressed concern that the reduction in the growth rate for the technical adjustment will exacerbate the lower-than-expected growth rates.

Response: We appreciate the concerns raised by the commenters. Section 1886(d)(11) of the Act directs the Secretary to provide inpatient prospective payment system hospitals with an additional payment amount for IME costs for discharges of MA enrollees, and section 1886(h)(3)(D) of the Act directs the Secretary to provide hospitals with an additional payment amount for DGME costs associated with services furnished to MA enrollees. The non-ESRD FFS USPCCs in ratebooks prior to CY 2024 had included both IME and DGME costs paid to hospitals on behalf of MA enrollees. Consequently, MA benchmarks prior to CY 2024 had included these admission-related costs even though CMS, and not MA organizations, had been paying these costs associated with MA enrollees directly to hospitals. That is, the non-ESRD FFS USPCCs in ratebooks prior to CY 2024 had included amounts paid for IME and GME associated with services for MA enrollees, and those are not costs for Part A and Part B services "for individuals who are not enrolled in an MA plan" per section 1853(c)(1)(D) of the Act.

Under authority in sections 1853(c)(1)(D) and 1876(a)(4) of the Act related to the development of the FFS per capita cost estimates used for MA rates, in response to comments, the Secretary

has directed the CMS Office of the Actuary to change the phase in of the medical education technical adjustment to the USPCCs to 52 percent of this medical education adjustment applied to the USPCCs in 2025.

Comment: A couple of commenters requested greater transparency with additional information regarding the calculation of the technical adjustment.

Response: The CY 2024 and CY 2025 Advance Notices indicated that the baseline development and modeling supporting the USPCCs had been updated to separately identify the historical and projected costs of IME and DGME paid to hospitals by CMS associated with services furnished to MA enrollees. This update in the modeling stems from separate projections of IME and DGME by FFS versus MA coverages.

We provided the preliminary impacts on the growth rates of the technical adjustment in the CY 2025 Advance Notice, and we now provide the final impacts of the technical adjustment in this Rate Announcement, for the FFS growth rate and the MA growth rate, so that stakeholders can understand how the technical adjustment will impact the county rates in their plan service area.

In the table below, we provide the updated impact of the technical adjustment for IME/DGME on the final estimate of the 2025 non-ESRD FFS USPCC (being released in this Rate Announcement). Note that the 2025 Part B non-ESRD FFS USPCC is unaffected by the technical adjustment for IME/DGME. As such, the following table illustrates the development of the 2025 Part A non-ESRD FFS USPCC including the technical adjustment.

| **Projection for Contract Year 2025** | With 33% implementation of technical update (*informational*) | With 52% implementation of technical update *for CY 2025 rates* | With full (100%) implementation of technical update (*informational*) |
|---|---|---|---|
| a. Part A FFS Enrollment (annual, in millions) | 32.712 | 32.712 | 32.712 |
| Reimbursements (in millions): | | | |
| b. Part A reimbursements including all MA medical education | $179,473.98 | $179,473.98 | $179,473.98 |
| c. MA medical education amount (as a negative number) | ($3,987.55) | ($6,283.42) | ($12,083.50) |
| d. Part A reimbursements excluding MA medical education<br>*d = (b + c)* | $175,486.43 | $173,190.56 | $167,390.49 |

| **Projection for Contract Year 2025** | With 33% implementation of technical update (*informational*) | With 52% implementation of technical update *for CY 2025 rates* | With full (100%) implementation of technical update (*informational*) |
|---|---|---|---|
| e. Part A FFS Admin loading | 1.001102 | 1.001102 | 1.001102 |
| f. 2025 Part A non-ESRD FFS USPCC<br>*f = [(d * e) / a / 12]* | $447.54 | $441.68 | $426.89 |
| g. 2025 Part B non-ESRD FFS USPCC | $689.17 | $689.17 | $689.17 |
| h. 2025 non-ESRD FFS USPCC<br>*h = f + g* | $1,136.71 | $1,130.85 | $1,116.06 |
| i. 2024 non-ESRD FFS USPCC from CY 2024 Rate Announcement | $1,105.10 | $1,105.10 | $1,105.10 |
| j. CY 2025 FFS growth rate<br>*j = h/i – 1 (rounded to hundredth of a percent)* | 2.86% | 2.33% | 0.99% |
| k. Impact of increase in phase-in on CY 2025 FFS growth rate (additive impact, compared to 33% phase-in) | n/a | -0.53% | -1.87% |

As stated earlier, we provided the preliminary impacts on the growth rates of the technical adjustment in the CY 2025 Advance Notice, and we now provide the final impacts of the technical adjustment in this Rate Announcement. For the MA growth rate, the updated impact of the technical adjustment for MA-related medical education expenses on the final estimate of the 2025 non-ESRD Total USPCC (being released in this Rate Announcement) is as follows. The impact of the increase in the phase-in on the final estimate of the 2025 MA growth rate being released in this Rate Announcement (based on the change in the non-ESRD Total USPCC, which includes both FFS and Part C projections) compared to the 2025 growth rate assuming 33 percent phase-in is -1.01 percent for full (100 percent) implementation of the medical education

change (provided for informational purposes) and -0.28 percent for 52 percent implementation in 2025.

***Estimates of non-ESRD USPCCs and Growth Rates***

Comment: A commenter acknowledged and appreciated CMS' continued effort to improve the level of detail regarding the methodology and components of the USPCCs and growth rates. Another commenter expressed appreciation for CMS' diligence in its growth percentage considerations and calculations.

Another commenter appreciated the information CMS included in the CY 2025 Advance Notice regarding the data and assumptions used to derive the USPCCs, including the IRA's Part B drug related provisions as well as the 340B remedy payments discussed on pages 17-18 of the CY 2025 Advance Notice, and the responses to questions provided in a widely attended actuarial user group call in February 2024.

Response: We appreciate the support.

Comment: A large number of commenters encouraged CMS to incorporate recent cost and utilization data (including fourth quarter 2023) and explore policy options to ensure that the CY 2025 MA benchmarks reflect higher utilization and cost trends and inflation observed by commenters. Commenters reported that a large number of MA organizations, as well as Accountable Care Organizations (ACOs), have experienced increased utilization (particularly in the fourth quarter of 2023) that may stem from delayed services during the COVID-19 pandemic and questioned why CMS has not detected a similar increase in utilization among FFS beneficiaries. Commenters expressed concern that the growth rates did not reflect higher utilization and cost trends in the U.S. health care market and the impacts of ongoing inflation that are expected to continue into 2025, and would be insufficient to cover the cost of care for Medicare beneficiaries in CY 2025 (including the long term costs associated with COVID-19) which could lead to higher beneficiary premiums and/or reduced supplemental benefits.

One of these commenters characterized the reduction in 2024 and 2025 FFS USPCC trends between the CY 2024 Rate Announcement and the CY 2025 Advance Notice to be "unsubstantiated," "unsupported," and "without explanation." A couple of commenters characterized the CY 2025 growth rates as "inadequate" that "do not reflect reality."

Several commenters expressed concern that downward restated estimates of FFS costs for 2024 and 2025, compared to last year's estimates, are inconsistent with higher utilization and costs seen elsewhere in the U.S. health care market, particularly for Medicare-eligible populations. Several commenters urged CMS to consider the full range of available sources when considering data that may be incorporated into the growth rate calculation.

A commenter noted that the 2025 FFS USPCC adjustment for prior periods stemmed from a decrease from 2022 to 2023 in Part A and a decrease from 2023 to 2024 in Part B, in part due to CMS assuming that outpatient utilization would not return to pre-pandemic levels, and found this assumption to be inconsistent with recent commentary from publicly-held hospital companies regarding 2023 and 2024 inpatient and outpatient volumes. Another commenter noted that their MA and Medicare Supplement (i.e., Medigap) internal data indicated that outpatient/Part B experience had accelerated throughout 2023, especially in the 4$^{th}$ quarter of 2023, and cited an MA plan survey showing accelerating outpatient utilization trends, which would indicate that outpatient utilization is still moving towards pre-pandemic levels.

A few commenters cited some specific causes of increased utilization and cost trend, such as seasonal vaccinations (ex: RSV), use of new Alzheimer treatments, uptick in Part B prescription drugs used to treat cancer, use of GLP-1 (Glucagon-like peptide-1) drugs, other Part B medical pharmacy treatments, and increases in musculoskeletal, circulatory system, and respiratory system surgeries. A few commenters noted the costs associated with compliance of recent MA regulatory requirements and noted that MA plans are facing the implementation of CY 2025 Part D changes, whereby MA-PD plans may need to allocate more rebates to keep Part D premiums paid by their enrollees from escalating.

Several commenters noted the cost growth of more than 7 percent in the 2023 FFS USPCCs (and over 6 percent in the 2023 Total USPCCs) in the CY 2025 Advance Notice and noted 2023 trends were higher than historical years. One of these commenters characterized the decline in trends for 2024 and 2025 FFS USPCCs when compared to the higher trends for 2023 (and 2026 and 2027) FFS USPCCs to be “an aggressive assumption” and “unsubstantiated” and not reasonable. A couple of commenters indicated that it was unclear why CMS was projecting cost growth in the CY 2025 Advance Notice of less than 4 percent for both 2024 and 2025. A commenter noted that the increase in the 2023 to 2024 Part B FFS USPCC is projected to be less than 4 percent, whereas the 2024 Medicare Part B premium had increased nearly 6 percent.

A couple of commenters noted an analysis that the FFS growth rate was lower than the trends that are observed when comparing the current estimates of the 2025 and 2024 FFS USPCCs (i.e., without factoring in any prior period adjustments) and noted that impacts will vary geographically. A few commenters noted that the 2024 and 2025 FFS USPCC trends were the lowest trend experienced since 2017, excluding 2022 (which was impacted by the COVID-19 pandemic). A couple of commenters indicated that the overall impact of the growth rate was among the lowest in a decade, compounding the low growth rate finalized in the CY 2024 Rate Announcement.

A couple of commenters requested that CMS ensure that adequate adjustments are included in the projections for the utilization trend in 2020-2023, the costs for providing care for people

dually eligible for Medicare and Medicaid and older populations disproportionately impacted by the pandemic, as well as the additional hospital, testing, and vaccination costs associated with COVID-19.

A commenter indicated that MA plans face many of the same cost pressures as commercial plans face, citing an MA plan survey regarding utilization and medical expense trends. A couple of commenters noted that MA plans face pressure from providers to increase payments considering inflation, workforce challenges, and continued pandemic-related costs. Several commenters expressed concern that lower-than-expected payment rates would be passed on to beneficiaries and providers, particularly value-based care arrangements.

A commenter acknowledged that CMS does not typically incorporate anticipated legislative changes into the projections, but expressed concern that potential legislation could increase provider payment, which would increase the risk that the CY 2025 growth rates may be inadequate. Another commenter urged CMS to incorporate any increase for Medicare physician payments into the final growth rate calculation if Congress passes legislation in the near future.

A commenter reviewed the non-hospice expenditures incurred through November 2023 in the January 2024 ACO REACH National Reference Population file, which indicated that fourth quarter 2023 trends are coming back up compared to the lower trends in the third quarter. The commenter expressed concern that CMS may be projecting based on the lower third quarter 2023 trends and that the assumptions supporting 2024 and 2025 "may not be actuarially sound" in light of the data supporting higher trends (based on recent announcements from publicly-held hospital companies, MA payers, and ACO REACH model data).

A few commenters expect that CMS will update the growth rates to incorporate actual claims experience through the fourth quarter of 2023, and implored that CMS consider the fourth quarter 2023 utilization data when developing the final CY 2025 growth rates.

Response: Section 1853 of the Act requires that FFS per capita cost estimates be used in developing MA rates and sets the general approach to updating the USPCCs and growth rates.

The USPCC modeling approach used by CMS reflects projected changes in the factors used to update Medicare FFS payment rates. The projected expenditures for some of the Medicare payment systems include the expectation of inflation including projected market basket changes for inpatient, SNF, home health agency, and outpatient hospital projections and consumer price index (CPI) updates for durable medical equipment projections.

The growth percentages are based on CMS' best estimate of historical program experience and projected trend at the time those values are announced. We continue to consider it best practice to base the growth rates on the most recent data and assumptions available at the time those

values are announced. Therefore, for each release of the growth rates, CMS updates historical enrollment and claims, as well as projection factors, based on the most recent data.

The baseline supporting the USPCCs and growth rates has been revised since the CY 2025 Advance Notice. A key change since the CY 2025 Advance Notice has been to incorporate 4th quarter 2023 spending into the USPCC baseline, as is typical when updating the baseline to include the most recent data for the Rate Announcement. We are aware of numerous reports from MA organizations and stakeholders stating that MA organizations' trends, especially for fourth quarter 2023, is inconsistent with the CY 2025 Advance Notice non-ESRD USPCC trends (that is, Medicare FFS cost trends). We are not aware of all of the specific drivers accounting for the experience of these MA organizations. We have reviewed incomplete fourth quarter 2023 Medicare FFS incurred experience and it is consistent with our projections.

Also, we are clarifying the CMS statement regarding recent outpatient trends relative to pre-pandemic trends. FFS baselines prepared prior to 2020 assumed increasing utilization of outpatient services for 2023 and beyond. There was a notable decrease in outpatient utilization during 2020, which is primarily attributed to the COVID-19 pandemic. Utilization has increased since 2020, but the actual 2023 utilization remains below the 2023 level reflected in pre-2020 projected baselines. Recent annual trends have returned to levels projected prior to the pandemic.

As reported in the CY 2024 Rate Announcement, over the last several years, a greater proportion of those dually eligible for Medicaid and Medicare have been enrolling in MA which has decreased the average FFS per capita cost for inpatient hospital, SNF, and home health spending and may be contributing to the faster spending growth for some MA organizations.

Comment: Several commenters characterized the CY 2025 growth rates as "not in line with available data" regarding Medicare costs and medical inflation and "ignores the financial and utilization realities." A commenter acknowledged that the published analyses are not inherently calculated in the same manner as the growth rates but found it concerning that the growth rates were "drastically different." Commenters cited published analyses of indicators higher than the growth rate including the following: National Health Expenditures (NHE) projections of Medicare spending, Congressional Budget Office estimates of Medicare spending, projections of medical cost trend/inflation by consulting firms, two MA plan surveys of utilization and cost trends, internal actuarial survey results, analyses of medical cost trends in the commercial market, analyses of medical inflation in the national health system based on the Bureau of Labor Statistics' CPI, and numerous public reports of MA plans' utilization and cost trends.

A commenter questioned why the 2025 FFS USPCC was not increasing at a higher rate given that the preliminary CY 2025 Maximum Out-of-Pocket (MOOP) limits (calculated using percentiles of estimated FFS beneficiary spend) were increasing at higher rates than the growth rates.

Another commenter indicated that the FFS USPCC trendline appeared to be inconsistent with CMS' Inpatient Prospective Payment System (IPPS) and Outpatient Prospective Payment System (OPPS) market basket updates, and it was unclear whether the final IPPS and OPPS rates were incorporated into the 2024 and 2025 growth rates.

Commenters expressed concern that the CY 2025 growth rate estimates were lower than specific estimates in the Medicare Trustees Report for 2024 and 2025 as well as specific estimates in the NHE projections (which reflected total Medicare expenditures including FFS, MA and Part D).

Response: We appreciate the comparison of the non-ESRD FFS trends in the CY 2025 Advance Notice to other representations of Medicare FFS experience. However, there are notable differences in timing, population, and services covered between the USPCCs and the other baselines.

For example, the published NHE and Medicare Trustees Reports are based on less current spending and projections than the CY 2025 Advance Notice and CY 2025 Rate Announcement USPCC baselines. The NHE and Medicare Trustees Report baselines also include beneficiaries in ESRD status, which are excluded from the non-ESRD USPCCs. Further, the NHE includes spending for hospice which is excluded from the USPCC baselines based on the scope of Part A and B benefits covered by MA plans.

Additionally, the calculation of MOOP is based on projected Medicare FFS beneficiary cost sharing whereas the USPCC baseline reflects Medicare FFS program expenditures. The MOOP tabulations are based on less current experience and include ESRD beneficiaries, which are excluded from the non-ESRD USPCCs.

Finally, the 2024 Part B Premium baseline is also based on less current experience. Also, the Part B premium determination takes into account other factors, such as maintenance of adequate surplus levels.

Comment: Several commenters expressed concern for perceived "inconsistencies" in the USPCC calculations since the FFS USPCCs in the CY 2025 Advance Notice for 2018-2022 were each 1.0 percent - 1.5 percent higher than the CY 2024 Rate Announcement, and 2023 had little change, but 2024-2026 were more than 1.0 percent lower.

Response: As discussed during the February 22, 2024 actuarial user group call,[3] there were two adjustments for 2018-2022 in the CY 2025 Advance Notice non-ESRD FFS USPCCs compared to the CY 2024 Rate Announcement:

[3] Refer to the call materials.

- Removal of 33 percent MA medical education phase-in for years prior to CY 2024. The pre-2024 reduction in the CY 2024 Rate Announcement USPCCs was incorrect but had no impact on the CY 2024 ratebook growth rates.
- Impact of 340B acquired drug remedy for 2018-2022 (as discussed on pages 17-18 of the CY 2025 Advance Notice). The lump sum remedy payments are reflected in the USPCCs of the respective year associated with the service experience.

The impact of these adjustments are summarized in the table below and they had no impact on the CY 2025 Advance Notice and CY 2025 Rate Announcement growth rates.

| Adjustment | 2018 | 2019 | 2020 | 2021 | 2022 |
|---|---|---|---|---|---|
| a. Remove 33% MA med. ed. pre-2024 | 0.40% | 0.44% | 0.54% | 0.60% | 0.67% |
| b. 340B acquired drug remedy | 0.60% | 0.66% | 0.73% | 0.72% | 0.72% |

Also, the lower non-ESRD FFS USPCCs for 2024–2026 are primarily due to lower 2023 actual experience than what was projected in the CY 2024 Rate Announcement.

Comment: A commenter requested clarification regarding whether the CY 2024 Rate Announcement FFS and Total USPCCs were developed using actual experience incurred through third or fourth quarter 2022. The commenter noted that in the "Narrative supporting 2024 growth rate," CMS stated that the "projections supporting RA 2024 are based on incurred experience through September 30, 2022 and cash activity through December 31, 2022" while page 42 of the 2024 Rate Announcement stated "The CY 2022 non-ESRD FFS USPCC is lower in the CY 2024 Advance Notice and CY 2024 Rate Announcement due to reflection of actual incurred experience through 3rd quarter 2022 in the CY 2024 Advance Notice and through 4th quarter 2022 in the CY 2024 Rate Announcement."

Further, the commenter requested that CMS clearly state whether the CY 2025 Rate Announcement uses actual experience incurred through 3rd quarter or 4th quarter 2023 and encouraged CMS to improve transparency regarding the USPCCs by publishing in future Advance Notices the incurred and paid through dates of the data supporting the USPCCs and any expected updates to the data supporting the Rate Announcement.

Response: We appreciate the opportunity to clarify this information. The non-ESRD FFS USPCCs in the CY 2025 Advance Notice were based on actual spending through September 30, 2023 and incurred experience through September 30, 2023. The non-ESRD FFS USPCCs in the CY 2025 Rate Announcement are based on actual spending through December 31, 2023 and incurred experience through September 30, 2023, as is typical for the Rate Announcement.

Comment: Several commenters expressed concern regarding the level of transparency regarding the analysis and assumptions used to calculate the growth percentages. A commenter urged CMS

to provide as much data as possible regarding cost trends impacting health care for the FFS cost projections for 2024 and 2025. Several commenters requested that CMS provide additional details of the information, analyses, methodologies, and assumptions used to determine the 2025 USPCC projections. A couple of commenters requested that CMS clarify the reasons for the lower growth percentages, including the extent to which it is a function of the medical education technical adjustment or other factors. Specific requests from commenters included the following:

- Additional details on the information and analyses used to update the assumptions supporting the revised 2024 Part B trend projection.
- A breakout of 2024 and 2025 FFS unit cost, utilization, and normalized trend assumptions by service category.
- An explanation of if and how emerging experience is factored into the development of the projection factors that support the final USPCCs.
- An explanation of the Part B drug projection methodology in more detail, such as at what level of detail projections are calculated (e.g., by drug class), which historical trends are used to project costs, and whether more weight is put on recent utilization and cost trend, and an explanation of how new to market drugs are accounted for in the projections and what criteria is used to determine whether a new to market drug or class of drugs will have an impact on Part B FFS spending.
- Trends in utilization and unit costs that may impact the FFS growth percentage.
- Details regarding how IPPS and OPPS finalized payment rates were incorporated into the USPCCs for 2024 and 2025.
- Details regarding utilization changes and unit costs by type of service.
- Additional details regarding the full impacts of costs associated with the COVID-19 pandemic, such as: vaccine cost and utilization for 2025, costs for providing care for older populations and dually-eligible populations that may be disproportionately impacted, additional hospital, testing, and vaccination costs associated with COVID-19, and long-term costs associated with COVID-19.
- An explanation regarding lower projected costs in light of higher historical costs.
- More specific information regarding the drivers of change in the historical and projected spending estimates.

Response: We discussed in the CY 2025 Advance Notice the methodology, sources of data, assumptions, and trends underlying the MA capitation rates at a level of detail consistent with past practice. In addition to the information provided in the CY 2025 Advance Notice, CMS also shared information about actuarial assumptions related to growth rates in its Actuarial User Group call on February 22, 2024.[4] Participants of the call were invited to ask questions about

[4] The Actuarial User Group call details were announced via HPMS memorandum on February 9, 2024.

assumptions supporting the CY 2025 Advance Notice growth rates. This call was widely attended by stakeholders, and the call's agenda and materials are available at https://www.cms.gov/medicare/payment/medicare-advantage-rates-statistics/actuarial-bid-questions.

In support of the MA ratebook growth rates, CMS has, as required under section 1853(b)(3), included an explanation of the assumptions and changes in methodology used in the CY 2025 Rate Announcement; see the key economic assumptions underlying the USPCCs included in Attachment II of this Rate Announcement. Consistent with prior years, with this Rate Announcement we have published additional information regarding trends for the prior five years and unit cost increases to the contract year at https://www.cms.gov/Medicare/Health-Plans/MedicareAdvtgSpecRateStats/FFS-Trends.html. This information includes additional details of drivers of historical and projected trends.

Additionally, the USPCC projections reflect payment levels based on the most recent Medicare final rules for fiscal year 2024 or calendar year 2024.

We believe that this information in the CY 2025 Advance Notice and now this Rate Announcement provides the necessary support for understanding USPCC levels and trends.

***ESRD Dialysis-Only USPCC and Growth Rate***

Comment: A commenter expressed appreciation for the additional explanatory information in recent years' Advance Notices regarding the methodology and assumptions used in developing the ESRD Dialysis-only FFS USPCCs, and appreciated CMS' commitment to offering stakeholders greater transparency regarding the assumptions and other factors that underpin the USPCCs.

Response: We appreciate the support.

Comment: A few commenters requested that CMS provide detailed information regarding the methodology and assumptions used to develop the ESRD growth percentage, including details pertaining to the change in the ESRD growth rate since the CY 2024 Rate Announcement. One of these commenters requested that CMS publish expenditure trends for beneficiaries with ESRD by service category.

A couple of commenters expressed concerns regarding the volatility of the ESRD growth percentage and urged CMS to consider opportunities to stabilize the ESRD growth rate from year to year. One of these commenters noted that restated ESRD USPCCs for 2022 and subsequent years are dramatically lower than the prior year estimates—ranging from a difference of -0.4 percent for plan year 2022 to a difference of -11.3 percent for plan year 2026. A commenter requested that CMS provide additional detail and explanation regarding the historical

restatements of the ESRD Dialysis-only FFS USPCC, particularly regarding the removal of an assumption that dialysis utilization will return to pre-2020 levels (i.e., changing the utilization assumptions between pre- and post-COVID levels, given the clinical need for consistency in dialysis treatment).

Response: As discussed in past Rate Announcements, we believe it is important to update the FFS per capita cost estimates using the most current FFS data available at the time those values are announced and apply repricing adjustments to reflect changes in FFS payment rules. Similar to prior Rate Announcements, the method for calculating the county-level non-ESRD rates and the state-level ESRD rates includes AGAs based on a five-year rolling average of historical claims experience, which provides some measure of stability in the rates.

The published 2023-2025 "Medicare Unit Cost Increases" by service category (available at https://www.cms.gov/files/document/ffs-trends-2023-2025.pdf) apply to provider payments for both ESRD and non-ESRD beneficiaries. Starting last year with the CY 2024 Rate Announcement posting, we have added trends for the ESRD Prospective Payment System (ESRD PPS) base rate.

As we discussed in the CY 2024 Rate Announcement, actual Medicare FFS per capita spending has been consistently below the pre-pandemic projections. In the CY 2024 Rate Announcement baseline, we assumed that ESRD per capita spending would return to levels reflected in the pre-pandemic baseline. Actual 2023 spending for ESRD beneficiaries, especially for dialysis services, did not return to that reflected in the pre-pandemic baseline. Accordingly, the ESRD projections for 2024 and later are based on recent experience instead of the pre-pandemic baseline. This update to the baseline resulted in lower projected ESRD spending starting in 2023.

Comment: A couple of commenters expressed concern that the Comprehensive Kidney Care Contracting (CKCC) model uses a Retrospective Trend Adjustment (RTA) based on restated projections of the ESRD USPCCs. One of the commenters inquired whether CMS takes into consideration or implements any changes in methodology due to the ESRD USPCCs' evolving role as the basis for CMMI model payment methodologies.

A couple of commenters expressed concern regarding the impact of the ESRD USPCC on the Kidney Care Choices (KCC) model and ACO REACH model. One of these commenters indicated that there were "unprecedented" forecast errors that occurred under the ESRD PPS in recent years.

Response: We appreciate the feedback regarding the payment policies of the Innovation Center models and the ESRD PPS.

Comment: A few commenters expressed concern regarding the adequacy of the ESRD rates relative to the cost of providing care. Another commenter expressed concern regarding the ESRD growth rate compared to the projections in the Medicare Trustees Report.

Response: The ESRD dialysis USPCCs are derived from the total ESRD USPCC baseline but are adjusted for recent trend differences between the total ESRD and dialysis ESRD populations. Thus, the ESRD dialysis USPCCs are projected using a base year USPCC, CY 2022 for the 2025 dialysis ESRD ratebook, trended from 2022 to 2025 using total 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. The applicable trends are found in the table in Attachment II, "Basis for ESRD Dialysis-only FFS USPCC Trend."

Comment: Several commenters requested clarification regarding whether the costs of oral-only ESRD drugs (e.g., phosphate binders) that will be paid for under Part B instead of Part D effective January 1, 2025 are accounted for in the development of the CY 2025 MA ESRD rates and if so, the amount of the adjustment. If not accounted for in the MA ESRD rates, one of the commenters inquired whether CMS has performed an analysis under the significant cost threshold policy, 42 CFR 422.109, until it is accounted for in the rates. A couple of these commenters noted a November 2023 GAO Report and asked CMS to consider the applicability of the significant cost threshold policy under 42 C.F.R. 422.109 until the costs for phosphate binders can be appropriately accounted for. A commenter noted that if the cost is considered in terms of the ESRD population (rather than the entire MA population) the total impact of adding these drugs to the base rate is significant. A couple of the commenters requested that CMS provide additional explanatory information on the methodology and assumptions used to incorporate these costs into the FFS Dialysis-only ESRD USPCC.

Response: Yes, oral-only ESRD drugs are represented in the 2025 Part B dialysis USPCC projection, resulting in a 2.47 percent increase in trend from 2024 to 2025. As a result, these new Part B costs are included in the CY 2025 MA rates and the significant cost test is irrelevant.

Comment: A few commenters expressed concerns regarding beneficiary access to new and innovative treatments given the contractual payment arrangements between providers and MA organizations regarding the 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 further suggested that CMS reimburse dialysis facilities directly for MA beneficiaries. Another commenter requested that CMS provide oversight to ensure MA plans are updating payment rates under their contracts to provide TDAPA or similar payment adjustments and collect data comparing utilization of these medicines in MA and FFS to ensure beneficiary access.

Response: We appreciate the commenters' feedback regarding adequately funding new and innovative treatments for beneficiaries with ESRD. We note that the TPNIES for eligible equipment and supplies and the TDAPA for drugs or biological products in existing ESRD PPS functional categories[5] are two-year add-on payment adjustments with no subsequent modification to the base rate. For drugs and biological products that meet the criteria for TDAPA payment and are not in an existing ESRD PPS functional category, CMS pays the TDAPA for at least 2 years, after which CMS may modify the base rate if appropriate.

The CY 2025 ESRD dialysis-only FFS USPCC reflects our best estimate of the national per-capita cost, including changes to the ESRD PPS bundled payments for variables such as payment adjustments to the ESRD PPS base rate, including the TDAPA and the TPNIES. We believe the current methodology for calculating MA ESRD rates account for products that receive the TDAPA or TPNIES under the ESRD PPS. CMS will continue to monitor and investigate complaints related to beneficiary challenges obtaining access to new and innovative products to determine if an MA organization has designed its plan benefits in an impermissible way or failing to cover Medicare Part A and B benefits (subject to limited exclusions) as required.

***Remedy for the 340B-Acquired Drug Payment Policy for Calendar Years 2018-2022***

Comment: A commenter indicated that CMS should incorporate the 340B OPPS lump sum remedy payment into the CY 2025 MA rates if CMS finalizes a policy to reduce MA rates due to budget neutrality adjustments in future years. The commenter believes it would be inconsistent and inequitable to finalize a policy that reduces future MA rates due to FFS budget neutral payment adjustments but does not incorporate the lump-sum remedy payment into the CY 2025 MA rates, and believes that incorporating the remedy into the CY 2025 MA rates would be consistent with how CMS is providing a payment increase to providers under FFS to correct for prior year payment decreases.

Another commenter requested confirmation that the lump sum payments for the portion of 2022 claims not reprocessed were included in the USPCCs.

Response: The USPCCs projected for 2025, which are used in developing MA rates for CY 2025, are based on projected Medicare FFS per capita costs for 2025. The 340B Remedy Rule[6]

[5] An ESRD PPS functional category is defined by § 413.234(a) as a distinct grouping of drugs or biological products, as determined by CMS, whose end action effect is the treatment or management of a condition or conditions associated with ESRD.
[6] The Hospital Outpatient Prospective Payment System Remedy for the 340B-Acquired Drug Payment Policy for Calendar Years 2018-2022 Final Rule, CMS-1793-F, was issued on November 2, 2023. The final rule appeared in the Federal Register on November 8, 2023, and is available online here: https://www.federalregister.gov/documents/2023/11/08/2023-24407/medicare-program-hospital-outpatient-prospective-payment system-remedy-for-the-340b-acquired-drug.

does not pertain to payments for 2025. We anticipate addressing how aspects of the 340B Remedy Rule might impact MA rates for other years in future policymaking.

Comment: A commenter urged CMS to address concerns regarding MA plans' payment to providers pertaining to 340B claims during 2018-2022 and the prospective outpatient rate reductions for non-drug items and services beginning in 2026. The commenter suggested that CMS either make lump-sum payments directly to hospitals or direct MA plans to pay providers, whereby the 2025 USPCCs include any additional funding needed for such payments. Further, the commenter suggested if additional payments are not made then CMS should direct MA plans to not apply prospective reductions, since the reductions are to offset a remedy payment that was not applied to MA.

Response: We appreciate the feedback on this issue. We refer commenters to the Hospital Outpatient Prospective Payment System Update on Payment Rates for Drugs Acquired through the 340B Program – Informational for MAOs memorandum that was issued by CMS on December 20, 2022.[7] As noted above, the 340B Remedy does not pertain to 2025 USPCCs. We anticipate addressing how aspects of the 340B Remedy Rule might impact MA rates for other years in future policymaking.

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

Comment: A few commenters urged CMS to use its administrative authority to eliminate the cap on benchmarks or exclude quality payments from the benchmark cap calculation. A couple of these commenters noted legal analysis provided to CMS on this topic in previous years that showed that they believed such changes were legally permissible.

One of these commenters encouraged CMS to consider the impact of the benchmark cap on the Administration goal to support health equity. A few commenters stated that the benchmark cap undermines the Quality Bonus Payment (QBP), whereby high-quality MA plans rated 4-Stars or higher will not receive the full QBP due to the benchmark cap which leads to fewer supplemental benefits for MA enrollees in high-quality plans.

A commenter expressed concern that the cap is inconsistent with Congressional intent. Another commenter expressed concern that certain counties are capped at "artificially low levels based on anomalous data from pre-ACA baselines" and that MA rates are not adjusted as intended for the quartile adjustment due to the benchmark cap and encouraged CMS to evaluate alternatives for outlier counties.

[7] Refer to the December 20, 2022 HPMS memo titled "Hospital Outpatient Prospective Payment System Update on Payment Rates for Drugs Acquired through the 340B Program – Informational for MAOs."

Response: As we have stated in response to similar comments in prior Rate Announcements, while we appreciate the commenters' concerns, we have not identified discretion under Section 1853(n)(4) of the Act to eliminate application of the pre-Patient Protection and Affordable Care Act (ACA) (Pub. L. 111-148) rate cap or exclude the bonus payment or quartile adjustment from the cap calculation. The applicable amount (i.e., "benchmark cap") is the rate established under section 1853(k)(1) of the Act.

Comment: A few commenters urged CMS to work on revising the Quality Bonus rate methodology so that they would be budget neutral similar to other Medicare bonus payments, reflect local MA plans' data rather than more aggregated contract-level data, and incorporate corrective action plans and sanctions for lower rated plans. A couple of commenters expressed concern that the Quality Bonus Program is ineffective at incentivizing high quality and equitable care delivery, with commenters noting the high proportion of plans that receive quality bonus payments.

Response: We appreciate the feedback submitted by the commenters regarding quality bonus payments. The statutory requirements regarding QBPs are prescribed in Section 1853(o) of the Act and our implementation complies with the statute.

The Patient Protection and Affordable Care Act (Pub. L. 111–148), as amended by the Healthcare and Education Reconciliation Act (Pub. L. 111–152), provides for quality ratings, based on a 5-star rating system and the information collected under section 1852(e) of the Act, to be used in calculating payment to MA organizations since 2012. Specifically, sections 1853(o) and 1854(b)(1)(C) of the Act were added and amended to provide, respectively, for an increase in the benchmark against which MA organizations bid and in the portion of the savings between the bid and benchmark available to the MA organization to use as a rebate. The Star Ratings measures are tied in many ways to responsibilities and obligations of MA organizations and Part D sponsors under their contracts with CMS. We have considered measuring performance at the plan versus contract level, but measurement reliability issues at the plan level due to small sample sizes decrease our ability to measure true performance and add complexities to the rating system. As discussed in the rulemakings that add, remove, or substantively update the Star Ratings measures and change the methodology for how Star Ratings are calculated, we believe the Star Ratings reflect plan performance and are appropriate for use in implementing section 1853(o) of the Act.

Comment: A few commenters encouraged CMS to explore alternative methods to apply the quartile adjustment (i.e., applicable percentage), such as: adjusting counties within a quartile by the same per-member-per-month (PMPM) amount (whereby the PMPM amount is computed as a percentage of the average per capita FFS costs within a quartile), increasing the number of

divided groups (ex: deciles instead of quartiles), and removing the quartile adjustment and instead blend county FFS costs with other measures of per capita costs (ex: USPCCs).

A couple of commenters suggested, in reference to MA rates in for Puerto Rico, that the quartile adjustment be based on a per-member-per-month (PMPM) amount for all counties in a quartile. More specifically for Puerto Rico, commenters suggested that CMS could apply the applicable percentage to the average per capita FFS costs of all counties that are in the bottom quartile and increase the territory county FFS cost by that PMPM dollar amount. Further, the PMPM amount that would be added to the territory FFS costs could be capped at no higher than 15 percent of the lowest non-territorial county per capita FFS cost, such that this proposed PMPM adjustment to the territories would not exceed the adjustments to non-territorial counties. One of the commenters indicated that this would be similar to the method used by CMS to adjust low wage index hospital payments in Part A.

Response: We appreciate the feedback submitted by the commenters regarding the applicable percentage adjustment (i.e., quartile adjustment). The statutory requirements regarding the quartile adjustment are prescribed in Section 1853(n)(2)(B) and (C) of the Act.

Comment: A few commenters supported CMS' interpretation of Sections 1853(o)(3)(B) and 1853(c)(1)(B) of the Act with regard to Puerto Rico counties that would have had an urban floor county rate, whereby more counties in Puerto Rico will continue to qualify for a double bonus.

Response: We appreciate the support.

Comment: A couple of commenters suggested that, for dually eligible beneficiaries enrolled in D-SNPs in Puerto Rico, the Part B premium buy-downs should be considered part of the A/B bid and not considered a supplemental benefit, since dually eligible beneficiaries in the mainland would have the Part B premium covered by Medicaid.

Response: Section 1854 of the Act specifies the costs that may be included in the bid submitted by each MAO. Per section 1854(a)(6)(A)(ii), the bid for basic benefits (that is, "the A/B bid") must separately address the costs attributable to provision of benefits under the Medicare FFS program (as defined in section 1852(a)(1)(B) as those items and services for which benefits are available under Parts A and B, excluding hospice and the costs of acquisition of a kidney for transplant), including, for plan year 2020 and subsequent plan years, the provision of additional telehealth benefits as described in section 1852(m) from any costs attributable to supplemental benefits and Part D benefits. Payment of the Part B premium is not a benefit under Medicare Part A or B but is a permissible use of the MA rebates. CMS does not have discretion under section 1854(a)(6)(A) to treat the payment of the Part B premium as a benefit under Part A or B.

**Section D. Calculation of Fee-for-Service Costs**

Comment: A commenter expressed support for the repricing refinements applied to the development of FFS costs.

Response: We appreciate the support.

Comment: A commenter urged additional transparency regarding the rebasing methodology, given the regional variations in pandemic impacts and to ensure accuracy and stability. Another commenter suggested that CMS release a preliminary estimate of the impact of rebasing/repricing the county rates at the time of the Advance Notice.

Response: We appreciate the request for transparency and believe that we have been responsive to stakeholders' interest in understanding and analyzing the rebasing methodology. As noted on page 29 of the CY 2025 Advance Notice, CMS released the 2022 FFS cost data by county used for rebasing county rates in the development of the 2025 ratebook. This data is available on the CMS website at https://www.cms.gov/Medicare/Health-Plans/MedicareAdvtgSpecRateStats/FFS-Data.html. Due to timing constraints, this publicly posted data did not reflect adjustments for Innovation Center models and demonstrations and the Medicare Shared Savings Program and Advanced Alternative Payment Models when posted, and the publicly posted data did not reflect adjustments for claim repricing for the most current available Medicare FFS payment rules and parameters. However, those adjustments are included in the data we used for the MA ratebook.

Starting with the CY 2020 Advance Notice, CMS has published with each Advance Notice the latest FFS cost data by county used in the development of the non-ESRD ratebooks. For the CY 2019 Advance Notice and prior, this FFS cost data was released at the same time as the Rate Announcement on the CMS webpage at: https://www.cms.gov/Medicare/Health-Plans/MedicareAdvtgSpecRateStats/FFS-Data. The accelerated release of the FFS experience allows stakeholders to conduct basic analyses of the impact of recent program experience on the geographic adjustments supporting the rates.

Comment: A commenter expressed support for the use of five years of FFS experience to mitigate any annual fluctuations and anomalies in the data.

Another commenter expressed concerns regarding rebasing the rates for CY 2025 pertaining to the potential for disparities across counties and requested that CMS consider a variety of alternatives, such as: make an adjustment for Puerto Rico for the impact of natural disasters, make an adjustment regarding the 2020 FFS experience impacted by the COVID-19 pandemic, rebasing less frequently (e.g., AGA update every three years).

Response: We appreciate the feedback submitted by the commenters and appreciate their concerns about stability in MA county rates.

The CY 2020 Advance Notice (page 21, in the context of developing MA rates for Puerto Rico) and Rate Announcement (pages 27 and 28, in response to comments about MA rates for Puerto Rico) included discussion and analysis of trends in the FFS data and concluded that our methodology of using five years of FFS experience mitigates annual fluctuations and anomalies in the data that may occur for a variety of reasons. The CY 2023 Advance Notice (pages 24 and 25) also discussed CMS' analysis of the trends in the 2020 FFS data that were impacted by the COVID-19 pandemic and affirmed our position that using five years of historical data provides for stability in the rates despite local or regional events, such as natural or weather-related disasters, and varying impacts from nationwide events, such as pandemics.

As discussed on page 22 of the CY 2025 Advance Notice, section 1853(c)(1)(D)(ii) of the Act requires CMS to rebase the county FFS per capita costs periodically, which entails updating the estimate of each county's FFS costs using more current FFS claims information. As discussed in past Rate Announcements, given that MA county rates are based on FFS costs, we believe it is important to update the FFS per capita cost estimates using the most current FFS data available and apply repricing adjustments to reflect changes in FFS payment rules. We have stated in previous Rate Announcements that we anticipate rebasing the rates each year. We have also previously discussed how the method for calculating the MA county rates includes a five-year rolling average of historical FFS claims experience, which provides a measure of stability in the rates. We are finalizing the proposal to rebase the CY 2025 rates.

Comment: A couple of commenters urged CMS to take action to mitigate negative downstream effects of significant unanticipated FFS payment adjustments for the contract year that are adopted in rules that come out after the Rate Announcement, such as the wage index calculations for rural reclassified hospital providers in last year's IPPS rule that dramatically increased costs to plans in certain regions – including upstate New York – with no corresponding adjustment in CY 2024 MA benchmarks due to the timing of regulatory actions. One of the commenters expressed concern that the CY 2025 Advance Notice did not indicate any adjustment to the rate methodology to account for the area-specific effects of its reinterpretation of the rural wage index. The commenter requested that, under the discretion allotted to the Secretary to estimate FFS costs in the geographic region under Section 1876(a)(4) of the Act, CMS further adjust the AGA factor to account for the "gap year" (i.e., CY 2024) in which the commenter states MA rates under-estimated actual area-specific cost experience. In addition, the commenter recommended that CMS take a more surgical approach to MA rate setting by applying an area-specific factor to the correction of prior year growth rates within and pursuant to the statutory authority and direction under 1853(c)(6)(C) based on the plain meaning of the statutory text.

The commenter indicated that in some regions, particular wage indices increased by as much as 43 percent, and the average increase across the Upstate NY region was approximately 26 percent, which is far above the 2 percent historical wage index increases and was the direct result of recent court decisions that overturned CMS' prior hospital rate methodology; the commenter described the fiscal implications of the changes in the wage index used for IPPS without corresponding changes in the MA rates for the same year as "unsustainable." The commenter also expressed concern that the benchmark cap and the quartile adjustment would negatively impact the MA rate updates for CY 2025 for the affected regions.

A couple of commenters noted that recent changes to the Medicare FFS wage index resulted in significant increases in payment rates for many California hospitals from MA plans beginning 2024, causing concern regarding maintaining affordable coverage for their enrollees. One of the commenters requested that CMS confirm whether this specific IPPS change is incorporated into the USPCCs and AGAs.

A commenter expressed concern regarding regions that experienced a significant increase in the Medicare wage index following the 2024 IPPS final regulation and requested that CMS account for these wage index variations in the 2025 MA rates.

Response: We appreciate the concerns raised by commenters. As discussed in past Rate Announcements, given that MA county rates are based on FFS costs, we believe it is important to update the FFS per capita cost estimates using the most current FFS data available and apply repricing adjustments to reflect changes in FFS payment rules. The CY 2025 USPCC projections reflect payment levels based on the most recent Medicare final rules for fiscal year 2024 or calendar year 2024. Section 1853(b)(1) of the Act prescribes the timing of the release of the MA capitation rates for the contract year and the risk and other factors to be used in adjusting such rates.

As noted on page 29 of the CY 2025 Advance Notice, CMS released the 2022 FFS cost data by county used in the development of the CY 2025 ratebook. The data is published on the CMS website at https://www.cms.gov/medicare/payment/medicare-advantage-rates-statistics. With the Rate Announcement, CMS annually publishes a tool and corresponding glossary, *Medicare FFS County 20YY web.xlsm*, which provides stakeholders with means to replicate the FFS rate development and publishes information regarding county-level geographic indices and repricing adjustments. Using this information, stakeholders are able to analyze the drivers of changes in FFS per capita costs for specific counties from one ratebook to another.

Comment: A commenter expressed concern that we are continuing to limit our adjustment of the AGAs for Innovation Center payment and service delivery models to those listed in Table II-4 of the CY 2025 Advance Notice, and with the proposed exclusion of certain payments under those models (e.g., care management fees) that are funded through the Innovation Center rather than

the Medicare Part A or B Trust Funds. The commenter inquired about the statutory basis for excluding these costs from the calculation of MA benchmarks and was concerned that as models expand in scope that a growing share of FFS spending may be excluded from MA benchmarks. The commenter expressed concern that the current approach fails to adequately determine the cost of providing a benefit to MA enrollees that is comparable to the cost of providing the benefit under FFS.

The commenter is particularly concerned about the exclusion of advance payment of shared savings and additional reconciliation payments paid to providers under Innovation Center models. The commenter requested that CMS reconsider policies that exclude Innovation Center costs and that CMS provide stakeholders with the amounts currently being excluded from the development of FFS costs.

Response: As explained on pages 34-35 of the CY 2025 Advance Notice, we considered adjusting the FFS claims experience for care management fees, per-beneficiary-per-month fees, and/or advance payment of shared savings paid using the Innovation Center appropriation instead of the Medicare Part A or B Trust Funds for other Innovation Center models conducted in the 2018–2022 period. However, in continuing prior policy, we will not take fees of this type into account in our adjustments to historical FFS experience when they were not funded under Medicare Part A or B Trust Funds.

As we discussed on page 20 of the CY 2018 Advance Notice, the fees paid from administrative accounts authorized by section 1115A of the Act are not from the Parts A and B Trust Funds, from which Medicare claims are disbursed, so we do not consider those payments to be part of FFS costs. Per section 1853(c)(1)(D)(i) and (n)(2)(F) of the Act, CMS uses the "adjusted average per capita cost for the year involved, determined under section 1876(a)(4) [of the Act]" as the base payment amount for setting MA rates. Section 1876(a)(4) indicates that FFS costs used for MA rates are based on the estimated amount that would be payable for services covered under Parts A and B, and types of expenses otherwise reimbursable under Parts A and B (including administrative costs incurred by organizations described in sections 1816 and 1842). As these costs described in section 1876(a)(4) of the Act are paid from the Trust Funds, excluding costs paid from another appropriation is appropriate to determine FFS costs. *See also* sections 1817 and 1841 of the Act. In addition, section 1853(f) of the Act indicates that payments to MA organizations shall be made from the Trust Funds "in such proportion as the Secretary determines reflects the relative weight that benefits under Part A and under Part B represents of the actuarial value of the total benefits under this title." Therefore, we will not make an adjustment to historical FFS claims to account for payments made from the funds appropriated under section 1115A(f).

Comment: A commenter expressed concern that there may be divergent trend patterns between the MA and FFS programs (for example, utilization patterns) and that as MA enrollment continues to increase, the MA rates would be based on a smaller and less-representative cohort in FFS. The commenter acknowledged that this concern may be outside of CMS' statutory authority to address.

A couple of commenters recommended that CMS incorporate an adjustment to the benchmark methodology for the differences between Medicare FFS and MA as a result of favorable selection, based on county-level MA penetration rates.

Response: We appreciate the concerns raised by commenters. The statute prescribes the general approach per section 1853(c) to updating the USPCCs and growth rates, and section 1853 of the Act requires that FFS per capita costs be used in developing MA rates, and our approach is consistent with the statute.

Comment: Several commenters requested that we calculate FFS spending using only claims and utilization data for beneficiaries enrolled in both Part A and Part B (rather than based on such data for beneficiaries in Part A and/or Part B, as is the practice today), because they believed that would be a more appropriate and/or equitable methodology. A couple of these commenters cited MedPAC's support of benchmarks calculated based on FFS data for beneficiaries with both Part A and Part B.

Several commenters pointed out that, in order to enroll in an MA plan, beneficiaries are required to be enrolled in both Part A and Part B and believe that the benchmark calculations should align with the population of beneficiaries eligible to enroll in MA plans. A couple of these commenters believes the current methodology is inappropriate from an actuarial perspective, as the current methodology includes beneficiaries who are not eligible to enroll in MA and stated that actuarial principles require that an estimate of the benchmark must represent what the MA enrollee would cost in FFS. Further, one of the commenters believes the Social Security Act requires that Part A-only enrollees be excluded from the calculation of county benchmarks to ensure that the estimate best represents what that enrollee would cost in FFS.

A couple of commenters expressed concern that, as the number of Medicare beneficiaries with Part A-only grows and as beneficiaries with only Part A tend to have lower costs, MA benchmarks may be distorted as artificially low and fail to reflect the FFS costs of the population eligible to enroll in MA, which the commenters believe results in actuarially inaccurate and inequivalent benchmarks. One of the commenters indicated that the difference in costs for individuals with Part A or B compared to individuals with Part A and B raises concerns that "CMS is not achieving actuarial equivalence when calculating the benchmarks."

A commenter cited an external analysis that examined the differences in Part A spending for those enrolled in Part A only versus those enrolled in Parts A and B, including over time as the share of FFS enrollees with Part A only has grown.

A couple of commenters noted that for a published public use file, the documentation released by the CMS Office of Enterprise Data and Analytics stated the following regarding per-capita spending for beneficiaries enrolled in Part A only or Part B only: "cannot be compared directly to spending for beneficiaries that are enrolled in both Part A and Part B."

A couple of commenters noted that in 2021, CMS had indicated that the agency intended to issue a Request for Information (RFI) on the topic of revising MA rates to be based on data from beneficiaries with both Part A and Part B, but no such RFI has been released.

A commenter stated that, similar to their belief that the adjustment made to per capita costs for Medicare beneficiaries who are dually eligible for benefits through the Department of Veterans Affairs and the Department of Defense (i.e., the VA/DoD adjustment) is needed because these beneficiaries are not enrolled in MA, a similar adjustment should be made for Part A-only and Part B-only beneficiaries who are not enrolled in MA (because they are not eligible to enroll).

Many commenters expressed support for continuing our policy of basing benchmarks in Puerto Rico on Medicare costs for beneficiaries with both Part A and Part B coverage. A couple of commenters requested that we apply a uniform approach in all counties to calculate benchmarks, pointing to the methodology used by CMS for Puerto Rico rates, to improve payment accuracy. A commenter suggested that CMS could implement a phased-in approach for counties with MA penetration over a certain percentage and gradually lower the threshold each year. Another commenter indicated it is unclear how the differing enrollment policy for Puerto Rico supports a differential approach to FFS data for the MA benchmark, characterizing the use of FFS data for beneficiaries with both Part A and Part B to be "equally applicable to the rest of the United States" given that MA enrollees must have both Part A and Part B.

A couple of commenters reiterated a request from last year that CMS revise the benchmark methodology for counties in Maryland, to be based on the FFS experience for beneficiaries enrolled in both Part A and Part B similar to the rate adjustment for Puerto Rico, due to the unique impact of the TCOC Model in establishing benchmarks for Maryland. A commenter indicated that Medicare FFS spending under the TCOC Model is higher than it would otherwise be under typical Medicare FFS payment rates (e.g., IPPS/OPPS) which results in most Maryland rates being adjusted downward by a 95 percent applicable percentage.

Response: We refer commenters to the detailed response that we provided in the CY 2020 Rate Announcement regarding use of FFS data for costs of all Medicare beneficiaries, whereby CMS concluded that it finds the current ratebook methodology (our longstanding policy of considering

costs of beneficiaries with Part A and/or Part B) to be consistent with the statute at Section 1853(c)(1)(D) of the Act. We continue to believe that it is not necessary to change the methodology at this time, nor is it required as the statutory language clearly permits CMS to include Medicare beneficiaries who have Part A only or Part B only. While we recognize that calculating rates based on data that excludes beneficiaries entitled only to Part A would yield different results than calculating rates based on our current methodology, that fact alone does not determine which methodology should be employed.

With respect to Puerto Rico, we have discussed in past Advance Notices and Rate Announcements that while most Medicare beneficiaries are automatically enrolled in Part B and must opt out to decline it, beneficiaries in Puerto Rico must take affirmative action to opt in to Part B coverage. As a result, we believe it is appropriate to adjust the FFS rate calculation for Puerto Rico used to determine MA rates so that it is based only on the Medicare costs for beneficiaries with both Part A and Part B.

Further, section 1853(c)(1)(D)(iii) of the Act explicitly requires an adjustment to the estimate of the FFS per capita cost for individuals dually eligible for benefits through the Department of Veterans Affairs and the Department of Defense. There is no statutory requirement for excluding cost data for beneficiaries with coverage for Part A only or Part B only from the information used to develop the FFS per capita cost estimate.

We appreciate the commenter's suggestion to revise MA rates in Maryland due to the impact of the TCOC Model on the FFS experience; however, the statute requires that MA capitation rates be based on FFS per capita costs, and does not provide CMS with the authority to calculate MA capitation rates based on what FFS per capita costs may be under different (hypothetical) circumstances.

The public use file documentation noted that beneficiaries enrolled in only one part of Medicare have different levels of per-capita spending than beneficiaries that are enrolled in both Part A and Part B. As noted above, while we recognize that calculating rates based on data that excludes beneficiaries entitled only to Part A would yield different results than calculating rates based on our current methodology, that fact alone does not determine which methodology should be employed.

We appreciate the suggestions submitted by commenters, and we will continue to analyze this issue and consider whether any adjustments to the methodology on this point may be warranted in future years. For CY 2025 we will continue to calculate FFS spending for the purpose of establishing MA benchmarks using FFS claims and utilization data for beneficiaries in Part A and/or Part B.

***Puerto Rico***

Comment: A commenter expressed appreciation for the special attention given by HHS and CMS to understand the unique challenges faced by the health system in Puerto Rico and differences between the mainland and Puerto Rico. A couple of commenters expressed appreciation for CMS' continued efforts to address the disparity between payment rates in Puerto Rico and the U.S. mainland.

Response: We appreciate the support.

Comment: The CY 2025 Advance Notice sought public comment on the possibility of adjusting FFS experience in Puerto Rico to reflect the propensity of zero-dollar beneficiaries nationwide. Many commenters supported the use of an adjustment to the Puerto Rico MA rates to reflect the prevalence of zero-dollar beneficiaries nationwide. One of the commenters indicated that such an adjustment is appropriate because the number of zero claimants in the Puerto Rico FFS population is a significantly greater proportion of the population relative to the rest of the United States.

Response: For the past eight years, the Secretary has directed OACT to adjust the FFS experience for beneficiaries in Puerto Rico to reflect the propensity of zero-dollar beneficiaries nationwide. For the CY 2025 ratebook development, the Secretary has directed OACT to adjust the FFS experience for beneficiaries in Puerto Rico to reflect the propensity of zero-dollar beneficiaries nationwide. For purposes of making this adjustment, consistent with the Secretary's instructions, OACT evaluated experience exclusively for beneficiaries that are enrolled in both Part A and Part B and are not also eligible for VA coverage.

The updated study analyzed experience for calendar years 2018 through 2022, using the cohort of FFS beneficiaries enrolled mid-year (i.e., enrolled in both Part A and Part B as of the mid-year dates used for the study) to approximate the average enrollment for the year. On average, 13.9 percent of Puerto Rico FFS beneficiaries with both Part A and Part B were found to have no Medicare claim reimbursements per year. This compares to a nationwide, non-territory proportion of 6.0 percent of FFS beneficiaries without Medicare spending. These results were applied to the Puerto Rico FFS experience by adjusting the weighting of the enrollment and risk scores for the zero-claim cohort to reflect the nationwide proportion of zero-claim beneficiaries. The resulting impact was an average increase in the standardized FFS costs in Puerto Rico of 4.2 percent for 2018 through 2022. Accordingly, a 4.2 percent adjustment was applied to the pre-standardized Puerto Rico FFS rates supporting the CY 2025 ratebook development.

Comment: A large number of commenters expressed concern regarding the disparity between payment rates in Puerto Rico and payment rates in the mainland and urged CMS to explore all potential options to increase MA benchmark rates in Puerto Rico to achieve greater parity with

the mainland and advance health equity. One of these commenters stated that the disparity in MA rates compromises healthcare quality and accessibility and also impedes crucial investments in Puerto Rico's healthcare infrastructure.

Commenters described historic socioeconomic and legal disparities and long-standing health inequities in federal programs, as well as a limited commercial health market in Puerto Rico. A couple of commenters noted that the Medicare payroll tax and Part B premium apply to beneficiaries in Puerto Rico and contrasted the level of federal funding provided under the MA program.

Many commenters compared the level of the standardized benchmarks in Puerto Rico to the national level and to other locales over a period of time (including low-income counties in the mainland), and one of these commenters provided statistical distributions of the county MA rates to characterize MA rates in Puerto Rico as outliers that are more than 3 standard deviations from the statistical mean. The commenter contrasted that analysis with a distribution of Part B Medicare rates for the ten most utilized services, in which Puerto Rico was well within 3 standard deviations.

A couple of commenters indicated that there have been changes in Medicare FFS payment policy that they would expect would position FFS per capita costs in Puerto Rico to be closer to the nationwide average, but the AGAs for MA benchmarks remain near 0.50, from which they conclude the ratebook methodology does not produce a rational result.

A large number of commenters noted that the MA program is critically important in Puerto Rico as the foundation of Puerto Rico's healthcare system with high MA penetration, noting the higher proportion of dually eligible beneficiaries in Puerto Rico whereby plans devote significant resources to addressing Health-Related Social Needs (HRSNs) to fill gaps in the healthcare system in Puerto Rico.

A few commenters recommended that we adjust the MA benchmarks in Puerto Rico to account for the proportion of dually eligible beneficiaries in the Puerto Rico FFS population. A few commenters suggested that we adjust MA benchmarks in Puerto Rico using the Area Deprivation Index (ADI) or other measures of socioeconomic status, citing VBID model flexibilities based on ADI and a Health Equity Adjustment in the ACO REACH model.

A large number of commenters suggested that we use a proxy factor in the development of the MA rates in Puerto Rico, such as applying the AGA level used for the US Virgin Islands or based on a national level or a budget neutral floor. A large number of commenters requested that we consider establishing a minimum AGA of 0.70 for Puerto Rico (similar to the AGA level in the US Virgin Islands). Several commenters suggested that CMS begin a phased-in approach in CY 2025 to implementing a minimum AGA (for ex: apply incremental increases based on

medical cost trends reported by recognized institutions). A commenter suggested that a minimum AGA be implemented in a manner that is not budget neutral.

A commenter believes that a minimum AGA would still satisfy the statutory requirement that "MA benchmarks be ***based on*** a county's average Medicare FFS per-capita cost" (with emphasis added).

A few commenters believed that certain polices in the Medicare FFS program (e.g., similar to the Part A Low Wage Index floor and monitoring of staffing compensation over a period of time) establish precedent for CMS to establish a minimum AGA and to monitor the impacts in addressing the needs of beneficiaries and supporting health care providers. A few commenters requested that CMS monitor and provide guidance regarding the use of funds for Medicare A & B benefits to positively address hospital infrastructure and provider compensation, whereby any additional funding provided to MA plans in Puerto Rico should include provisions that address better reimbursement for providers such as the use of guardrails to ensure additional funding to applied directly to physicians and hospitals.

Several commenters indicated that increases to MA rates in Puerto Rico will positively impact the health care delivery system, including the hospital infrastructure, provider compensation and support, the quality of services received by MA enrollees, overall economic growth in Puerto Rico, and incentivize more healthcare providers to participate in the Medicare program in Puerto Rico. Several commenters indicated that low MA rates play a major role in provider and professional migration from the island, leading to access and quality issues which are exacerbated by hurricanes, earthquakes, and the COVID-19 pandemic.

A couple of commenters noted a decline in the number of FFS beneficiaries in Puerto Rico over the past four years, which they believe undermines the use of FFS data to calculate MA rates. Several commenters characterized the FFS data used for MA rates in Puerto Rico to be "inadequate," given the relatively small proportion of Medicare beneficiaries remaining in FFS with low utilization of medical services considered to be not representative of the Medicare beneficiaries in Puerto Rico and differing statutory treatment and exclusion from federal benefit programs. Further, one of the commenters noted that a MedPAC analysis had excluded Puerto Rico due to the relatively small number of FFS beneficiaries in that territory, and further noted that 90 percent of counties in Puerto Rico have a credibility adjustment in the MA rate calculation (which results in Puerto Rico accounting for the majority of all counties that require a credibility adjustment).

Another commenter urged CMS to consider whether the FFS data in Puerto Rico meets the statutory language at Section 1876(a)(4) that the average per capita cost be "based upon an *adequate* sample" (with emphasis added). A few commenters provided analyses of FFS data in Puerto Rico which indicated that the FFS data that is used as the basis for MA rates is not robust

and is not representative of MA enrollees in Puerto Rico, due to the proportion of beneficiaries with zero FFS claims, the relatively small number of FFS beneficiaries, and the low proportion of dually eligible FFS beneficiaries in Puerto Rico. A couple of commenters provided analyses of hospital costs and provider compensation in Puerto Rico, the US Virgin Islands, and nationally.

A couple of commenters indicated that CMS should "avoid the mistaken perception" that higher levels of supplemental benefits and market competition as suggesting that MA benchmarks are adequate. Several commenters indicated that these supplemental benefits are necessary to address the extreme concentration of poverty in Puerto Rico given the statutory exclusion from numerous federal benefit programs (ex: Low Income Subsidy, Medicare Savings Program) and further advocated that these federal benefit programs should be provided to beneficiaries in Puerto Rico. A commenter stated that "the MA program in Puerto Rico is structurally obliged to cover higher-than-usual supplemental benefits." Further, a couple of commenters stated that higher risk scores in Puerto Rico should not be used to minimize the disparity in MA rates, given the population profile with higher morbidity and prevalence of chronic conditions than other jurisdictions. A commenter provided details regarding the specific types of supplemental benefits offered in Puerto Rico, and an analysis of the proportion of MA rebates used for categories of supplemental benefits.

Response: CMS thanks commenters for their thoughtful comments regarding alternate adjustment approaches that may be appropriate in Puerto Rico and appreciates the concerns about access to health care in Puerto Rico. CMS shares the concerns about access to health care for U.S. citizens in Puerto Rico, including because of health care providers who are leaving Puerto Rico. Bid data shows that MA plans in Puerto Rico have the lowest bid-to-benchmark ratio, most spending on supplemental benefits, and highest rebates compared to any U.S. state. CMS has implemented policies that apply only to, and increase payments for, Puerto Rico, including those the agency is finalizing for 2025. Over time, however, standardized plan bids, which are used to pay doctors and medical providers for providing required Medicare A and B benefits, have remained relatively flat. As part of the annual bid review process, CMS will carefully review bids to ensure that bids reflect the costs needed to provide required services.

We appreciate the suggestions and recommendations submitted by commenters. However, we note that section 1853 of the Act prescribes the general approach that FFS per capita costs be used in developing MA rates and CMS has limited discretion to incorporate targeted adjustments or exceptions.

As noted in prior Advance Notices, the law requires that MA benchmarks be based on a county's average Medicare FFS per capita costs, and there is no evidence that FFS costs in Puerto Rico are higher than the costs observed in the FFS claims data and thus no basis for overhauling

Puerto Rico's MA benchmarks. Section 1853(c)(1)(D) requires an estimate of the per capita costs for services covered under Parts A and B for individuals who are not enrolled in an MA plan. We believe that using data pertaining to actual Medicare FFS costs in Puerto Rico is the best approach to developing the estimate of FFS per capita costs for the contract year and we have not seen evidence to suggest that Medicare FFS costs in another jurisdiction are a reliable proxy. As we stated in the CYs 2017 and 2018 Rate Announcements, and based on the number of FFS beneficiaries used in development of 2025 ratebook FFS rate we have determined that the FFS data in Puerto Rico is sufficient for establishing accurate MA benchmarks. As noted on page 37 of the CY 2025 Advance Notice, the credibility adjustment is used for counties that have certain levels of FFS beneficiaries.

In response to a commenter's suggestion that there is precedent under the Medicare FFS program (e.g., under the Physician Fee Schedule, ESRD PPS, IPPS) for CMS to establish a minimum AGA, we note that these examples are based on statutory provisions that are neither applicable to the MA program nor provide a direct analog to the provisions in section 1853 that determine the formula for setting MA capitation rates.

As commenters noted, comparisons of the standardized MA rates in Puerto Rico to other geographic areas and nationally is one informative measure. The standardized MA rates are used to calculate benchmarks for the bidding process. MA plan payments are not solely based on the level of standardized MA rates, rather MA payment is based on risk adjusted plan bids and rebates, intended to cover the expected cost of plan benefits under Part A and Part B and for supplemental benefits. Total actual MA payments to plans is another informative measure of MA funding. Public use data files regarding actual MA plan payments are available at: https://www.cms.gov/medicare/health-drug-plans/plan-payment-data.

Each year, since CY 2006, MA organizations submit plan bids to CMS that detail the projected revenue needed to cover the expected per beneficiary costs of their enrollee population. Risk adjustment is used to adjust plan bids for payment, based on health status and demographic characteristics (such as dual eligible status) such that plans are paid more for beneficiaries predicted to have higher costs. Comparisons of these plan-submitted bids to the benchmarks is another informative measure of plans' expected funding needs for benefits under Part A and Part B. Public use data files regarding MA bids are available at: https://www.cms.gov/medicare/payment/medicare-advantage-rates-statistics/data.

**Section E. Direct Graduate Medical Education**

***Maryland TCOC Model***

Comment: Commenters were concerned about the proposed change, indicating that the current methodology has been helpful to MA organizations to manage revenue shortfalls stemming from the TCOC model and the quartile adjustments in Maryland. The commenters believe that the proposed AGA methodology change in the CY 2025 Advance Notice would remove financial value, further disadvantaging MA organizations in Maryland, particularly impacting Baltimore City and Baltimore County, which are home to higher-cost teaching hospitals. These commenters state that this methodological change will create added challenges in serving lower income members, beyond the already low growth rate proposed in this year's Advance Notice.

Commenters highlighted that the Baltimore area has a high proportion of individuals from marginalized communities facing disparities in health care and social risk factors related to income, education, and health status. Commenters also stated that Baltimore City has a household income approximately half the Maryland state average; a poverty rate nearly twice as high, and a higher rate of disability. Commenters indicated that for CY 2025, 22 out of Maryland's 24 counties are in the 95 percent quartile (including Baltimore City and Baltimore County) and adjusting payments to plans downward relative to FFS will further exacerbate the already challenging financial environment for MA plans operating in Maryland. A commenter expressed concern that the proposed methodology would disproportionately impact low-income beneficiaries and could have significant health equity implications.

Response: We appreciate the support for improving the accuracy of the MA rates and benchmarks for service areas in Maryland. The methodological change will result in more accurate projections of FFS per capita costs for Maryland, in order to adhere to the statutory requirements under 1853(c)(1)(D)(i), 1853(k)(4), and 1853(n)(2)(F) of the Act. The CY 2025 Advance Notice indicated that CMS had worked to identify data that could be used to develop the DGME and IME carve-outs for hospitals participating the Maryland TCOC Model, thereby lowering MA rates in Maryland. Even with this change, MA rates in Maryland continue to be among the highest in the country compared to the average MA rates of other states.

As stated in the CY 2025 Advance Notice on page 52, the Maryland TCOC Model sets a per capita limit on Medicare total cost of care in Maryland and is the first Innovation Center model to hold a state fully at risk for the total cost of care for Medicare beneficiaries. The TCOC Model builds upon the Innovation Center's Maryland All-Payer Model, which had set a limit on per capita hospital expenditures in the State. Maryland operates an all-payer hospital rate regulation system. This system is made possible, in part, by a Medicare waiver (codified in section 1814(b) of the Act) that exempted Maryland from IPPS and OPPS and allowed Maryland to set rates for these services. This exemption affects the CMS system data used to develop the DGME and IME

carve-outs, and as such we have worked with the Medicare Administrative Contractor and Maryland's HSCRC to identify data that can be used to develop the DGME and IME carve-outs for hospitals participating in the Maryland TCOC Model.

We appreciate the concerns raised by the commenters, and we will continue to analyze this issue and consider whether any adjustments to the methodology may be warranted in future years.

Comment: Several commenters recommended CMS delay implementation or phase in the implementation of this methodological change, similar to the way CMS is phasing in the technical correction to USPCCs, to mitigate the impact on enrollees and allow health plans operating in Maryland to adjust to this additional revenue impact. The commenters also urge CMS not to adopt the proposed AGA methodology change for CY 2025, in the interest of supporting MA and Medicare beneficiaries in Maryland. Commenters also state that sufficient lead time to prepare for this type of change allows for better bid planning, thereby easing potential member impact.

Another commenter supports better alignment between the data used to develop the carve-out with expected capitation rates, but believes additional time is required for MA plans to analyze the impacts of any updated methodology and that CMS should reconsider its proposal to give MA plans additional time.

Response: CMS is finalizing the methodology change as proposed in the CY 2025 Advance Notice because this change in the data source and methodology for calculating the MA rates in Maryland will more accurately reflect FFS per capita costs and will result in developing more accurate estimates of the FFS per capita costs for the payment year that are the basis for MA rates as required by the statute. Section 1853(c)(1)(D)(i) of the Act requires the exclusion of costs attributable to payments under section 1886(h), that is payments for DGME, from the FFS per capita costs used for developing the MA ratebooks. Furthermore, section 161 of the Medicare Improvements for Patients and Providers Act of 2008 (MIPPA) (Pub. L. 110-275) amended section 1853(k)(4) of the Act to require CMS to phase out IME amounts from MA capitation rates. Section 1853(n)(2)(F) applies the same phase-out to FFS costs in the calculation of the specified amount in setting MA rates. In addition, implementing this change in one year is consistent with how, in the CY 2023 Rate Announcement, we fully implemented the change in the methodology for the development of DGME amounts to using the provider specific file data to estimate amounts instead of the inpatient Medicare cost reports.[8]

[8] Refer to CMS' CY 2023 Rate Announcement.

The change in data source pertaining to Maryland TCOC model (described in detail in sections C1 (DGME) and C3 (IME) of the CY 2025 Advance Notice) results in a more accurate projection of per capita costs because the revision will properly exclude medical education costs.

Comment: A few commenters urged CMS to both clarify the proposed methodology and provide more information to stakeholders about the proposed change in methodology, including how DGME and IME costs are calculated in Maryland under current methodology and why CMS believes the calculation change is necessary.

Response: Previously, the data used for the ratebook development did not separately identify medical education costs for providers participating in the Maryland TCOC Model. The updated data source and methodology described in the CY 2025 Advance Notice will lead to more accurate MA rates in Maryland. As stated in the CY 2025 Advance Notice, 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 PS&R includes for each Maryland provider the fiscal year MA DGME and IME expenditures and MA days of admission, which are used to calculate the DGME and IME per diem for MA admissions. This MA experience is used as the basis for the FFS DGME and IME amounts since DGME and IME payments for FFS admissions are not specified in the inpatient Provider Specific File and the National Claims History file for providers participating in the Maryland TCOC model. The CY 2025 Advance Notice provided the specific calculation steps when using this data.

**Section F. Organ Acquisition Costs for Kidney Transplants**

Comment: A commenter requests that CMS consider how other changes may affect county benchmarks and that CMS acts to limit the impact any such changes will have in a single year.

Response: We will 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 for future years.

Comment: A commenter appreciated that CMS provided notice in advance of its intention to calculate Maryland hospital-specific adjustments for kidney acquisition costs and requests the opportunity to review the methodology before the release of the Advance Notice and requests to phase in the impact of such methodology changes over several years in order to mitigate disruption to county benchmarks across the state.

Response: We appreciate the feedback.

Comment: A commenter expressed continued support of the use of the kidney acquisition costs carve-out methodology and thanked CMS for their work in this space.

Response: We appreciate the support.

**Section G. IME Phase Out**

***Maryland TCOC Model***

*See Comments and Responses in the section titled "Direct Graduate Medical Education."*

**Section H. MA ESRD Rates**

Comment: The majority of commenters on this topic expressed concerns that ESRD rates are not sufficient to cover the cost of care for beneficiaries with ESRD. The commenters requested that CMS continue regular evaluations of ESRD rates to improve the stability, adequacy, and accuracy of MA ESRD benchmarks and payment, particularly given the increasing number of beneficiaries with ESRD in MA plans. Commenters highlighted the potential consequences of inadequate rates, including impacts to all MA beneficiaries through increased premiums and cost-sharing, reduced benefits, and fewer plan options.

Response: CMS appreciates the comments regarding MA ESRD payment adequacy given the increased enrollment into MA plans by beneficiaries with ESRD. CMS continues to analyze these issues and consider whether, consistent with the statutory requirements for setting ESRD rates in section 1853(a)(1)(H) of the Act, any refinements to the methodology may be warranted in future years to ensure appropriate ESRD payment rates.

Comment: Several commenters supported setting MA ESRD rates at the state level. One commenter expressed concerns that a smaller geographic unit would not provide adequate data to establish appropriate rates. Another commenter noted that rates set at the Core-Based Statistical Area (CSBSA) level might have negative impacts on medically underserved areas, which often have high rates of kidney disease. However, a majority of commenters on this topic expressed concern that the state-based rate-setting methodology results in rates that are inadequate to cover costs in certain markets. Many of these commenters noted that expenditures for ESRD care in metropolitan areas can deviate from the state average, indicating the need for a more localized approach in setting payment rates, and encouraged CMS to continue exploring other options to state-based payments using smaller geographic units. Commenters acknowledged that certain areas, such as rural and medically underserved areas, could receive lower rates under a new methodology, and suggested CMS consider adjustments to these areas to ensure continued access to services.

Response: CMS appreciates the comments regarding ESRD rate setting and refers commenters to our analyses of sub-state ESRD rates provided in the CY 2023 and CY 2024 Advance Notices. In the CY 2024 Advance Notice, we provided details of our analysis of potential changes in ESRD rates by CBSA, showing that CBSAs representing the 40 percent of enrollment with the

highest ADI measures were expected to receive CY 2022 ESRD rates that were an average of 2.13 percent lower under the CBSA-level approach. We believe our longstanding rate-setting approach is fair and reasonable, and agree with commenters that significant changes to the current methodology should be fully examined prior to implementation. CMS will continue taking into consideration commenters' concerns and recommendations.

Comment: Several commenters stated concerns that the MOOP limit is a factor contributing to underpayment for beneficiaries with ESRD. Commenters suggested that CMS update the MA benchmark to incorporate the difference between FFS Medicare out-of-pocket (OOP) costs and the MA MOOP to directly increase payments for beneficiaries with ESRD.

Response: While we appreciate the suggestions of commenters, we do not find the suggestions to revise the ESRD rate-setting methodology to be consistent with our interpretation of section 1853 of the Act. As explained in the CY 2012 Advance Notice and CY 2012 Rate Announcement, CMS interprets the legislative changes made by the ACA to MA payment to indicate that all MA payment rates, including the separate rates of payment for ESRD enrollees, should closely align with FFS Medicare costs. As provided in section 1853(a)(1)(H) of the Act, CMS establishes separate rates of payment to MA organizations for ESRD beneficiaries enrolled in MA plans. See also §§ 422.254 and 422.304 through 422.308. The rates used for enrollees in dialysis or transplant status are based on statewide average FFS Medicare costs for ESRD beneficiaries in dialysis status. For enrollees with functioning graft status, the MA county benchmark rates are the payment rates. The rates for those in dialysis, transplant, and functioning graft status are also adjusted using a risk adjustment methodology that is specific to the health care costs for beneficiaries with ESRD in dialysis, transplant or functioning graft status. We understand the concern about potential subsidization of ESRD costs by enrollees without diagnoses of ESRD, however the data CMS uses to calculate the CY 2025 MOOP limits includes OOP expenses from beneficiaries with and without diagnoses of ESRD because the MOOP limits will apply to enrollees with and without diagnoses of ESRD in CY 2025. This practice avoids discriminating against beneficiaries with diagnoses of ESRD — or any group of beneficiaries with a particular high-cost condition or health status — that would result if there were higher premiums, cost sharing, or MOOP amounts applicable only to those individuals with a certain chronic condition. Additional detail on how CMS finalized MOOP limits calculations, including the data used and the percentiles of FFS Medicare data projections that should be used in those calculations is available in the final rule titled "Medicare Program; Maximum Out-of-Pocket (MOOP) Limits and Service Category Cost Sharing Standards" (CMS-4190-FC4) (87 FR 22290) published April 14, 2022.

Comment: A few commenters recommended CMS make changes to the Bid Pricing Tool (BPT) so that the ESRD subsidy falls under Medicare-covered benefits instead of under Mandatory Supplemental benefits. The commenters suggested that in the short term, CMS should make the

ESRD and non-ESRD service categories consistent and merge the ESRD and MA BPT format, and in the long-term, CMS should eliminate the ESRD BPT filing altogether.

Response: We appreciate the suggestions submitted by the commenters related to the BPT. Section 1853(a)(1)(H) of the Act authorizes CMS to establish "separate rates of payment" with respect to beneficiaries with ESRD enrolled in MA plans and does not require that a competitive bidding methodology be used for CMS capitation payments for ESRD enrollees. In setting such separate rates, CMS has established an approach for paying MA organizations for enrollees with ESRD that directly use the rates, rather than bids. As such, the ESRD rates are intended to be the base rate for enrollees with ESRD, and these costs cannot be paid under the rates used in the bids to determine payment for non-ESRD beneficiaries. Therefore, the ESRD subsidy that is permitted in plan bids for non-ESRD beneficiaries will remain as a mandatory supplemental benefit. Regarding the commenters' request that CMS eliminate the ESRD C-SNP BPT filing requirement, we will continue to analyze this issue and consider whether any adjustments to reporting may be warranted in future years.

Comment: A commenter requested that CMS work with the National Institute of Diabetes and Digestive and Kidney Disorders and other partners to identify and close data gaps in the United States Renal Data System related to beneficiaries with kidney disease with MA coverage.

Response: CMS notes that this issue is outside of the scope of this document.

Comment: A commenter suggested that CMS expand access by allowing MA plans to participate in the Innovation Center's kidney demonstration models, expanding the ESRD Chronic Condition Special Needs Plans (C-SNP) to include beneficiaries with chronic kidney disease (CKD), and modernizing Medicare conditions for coverage to provide beneficiaries with ESRD the choice to receive care in their preferred home or in-center dialysis setting, when clinically appropriate.

Response: CMS notes that potential demonstrations and changes to ESRD regulations are outside the scope of this document.

**Section I. MA EGWPs**

Comment: Several commenters expressed their support for EGWPs and requested that CMS consider the nuances of the EGWP environment, such as the multi-plan year contracts generally signed by public sector stakeholders for their EGWPs and the healthcare needs of public sector retirees.

Response: We appreciate the support.

Comment: Several commenters expressed support for the continuation of the current payment methodology for CY 2025.

Response: We appreciate the support.

Comment: Some commenters expressed appreciation for the inclusion of the preliminary bid-to-benchmark ratios for EGWPs in the Advance Notice to facilitate more accurate benefit and premium information for employers and beneficiaries.

Response: We appreciate the support.

Comment: Some commenters recommended CMS exclude negative margin plans from the calculation of estimated bid-to-benchmark ratios for EGWPs to avoid undermining the availability of supplemental benefits and limiting EGWPs ability to expand.

Response: As we have noted in past Rate Announcements, we do not believe that there is a reasonable rationale to exclude these plans because the ratios are intended to be representative of the market. Negative margin plans are included in the non-EGWP market as well, so the bids of such plans are included when the bid-to-benchmark ratios are developed. CMS does adjust for factors which would otherwise result in significant differences between the EGWP and non-EGWP market. More specifically, because the majority of plans in the EGWP market are PPO plans and the non-EGWP market is predominantly HMO plans, EGWP bid-to-benchmark ratios are calculated separately for HMO and PPO plan types by quartile. Unlike the HMO/PPO difference between EGWP and non-EGWP plans, there is no data to suggest that a similar difference exists between EGWP and non-EGWP plans regarding negative margin plans upon which CMS can judge the reasonableness of adjusting the bid-to-benchmark ratios to account for negative margin plans.

Comment: Some commenters expressed support for the continuation of the policy permitting EGWPs to buy down Part B premiums. A commenter suggested that to reduce the number of PBPs submitted, CMS should establish a process using segment ID to facilitate additional flexibility with Part B buy-downs.

Response: We appreciate the commenters' support. As described in recent past Advance Notices and Rate Announcements, when an MA organization submits an individual market MA plan bid to CMS, the MA organization is permitted to use MA rebates to buy down a portion of the Part B premiums for its enrollees in each PBP by identifying the buydown amount in the BPT as its use of the beneficiary rebate. We then retain that rebate amount specified by the MA organization in each PBP and coordinate directly with the Social Security Administration (SSA) to ensure that each beneficiary's Part B premium is appropriately calculated and takes into account the buy-down amount, which is uniform for all enrollees in the PBP. In the Advance Notice, we

described a similar implementation for MA EGWPs: the Part B premium buy-down amount cannot vary among beneficiaries enrolled in an EGWP. (In addition, the Part B premium buy-down amount is limited to a maximum amount described in CMS guidance issued prior to the bid deadline.) Implementing the bidding waiver as described in the Advance Notice facilitates the communication of this information throughout CMS systems by maintaining an operational structure that is similar to the one that exists for individual market MA plans. For this reason, we decline to make the recommended changes, but we appreciate the commenter's thoughts on this issue and will continue to analyze and explore suggestions for refinements to this policy in the future.

Comment: A commenter suggested adjusting current rate setting to capture differences in the use of HMO and PPO plans between the EGWP and non-EGWP markets. The commenter believes it would be more accurate for CMS to segment the benchmark calculation by HMO and PPO products and adjust the bid-to-benchmark ratio for the differing products accordingly.

Response: We appreciate this suggestion; however, we are continuing to apply our current methodology for paying EGWPs in CY 2025. Consistent with how we have developed EGWP payments since 2019, the CY 2025 EGWP payment methodology takes into account the prevalence of HMO and PPO enrollment in the EGWP market by calculating CY 2025 individual market bid-to-benchmark ratios separately for HMO and PPO plan types by quartile. CMS then takes into account the prevalence of HMO and PPO enrollment in the EGWP market to combine the ratios by quartile. This methodology is more consistent with the county rates for individual market plans, which are also not calculated separately for HMO and PPO plan types.

Comment: Several commenters encouraged facilitating greater access to EGWPs in rural markets. Commenters noted that implementing additional flexibilities around telehealth for provider network requirements could address factors that inhibit the formation of direct contract networks and enable more EGWPs to be offered in rural markets.

Response: We believe this comment is unrelated to our proposals in the CY 2025 Advance Notice. This comment is about EGWP availability, service areas and network adequacy considerations, rather than EGWP payment policy. We note that CMS has waived certain service area requirements that hinder the design of, the offering of, or the enrollment in EGWPs. To enable employers/unions to offer coordinated care plans to all their Medicare-eligible members wherever they reside, CMS has waived certain service area requirements for EGWPs; we encourage readers to review Chapter 9 of the Medicare Managed Care Manual for more information on EGWP waivers.

Comment: Several commenters requested that CMS enable professional or group associations to pool membership to enroll in EGWPs.

Response: CMS notes that membership in EGWPs and the scope of non-payment EGWP waivers are outside of the scope of this document. We refer readers to Chapter 9 of the Medicare Managed Care Manual for more information on EGWP waivers.

Comment: A commenter requested that CMS provide updated bid-to-benchmark ratios based on February enrollment data in advance of the Rate Announcement release to reduce operational pressures on MA plans with short windows for the negotiation and finalization of bids.

Response: We appreciate this recommendation. In response to feedback from the industry, CMS began publishing preliminary bid-to-benchmark ratios for EGWPs based on January enrollment data in the CY 2023 Advance Notice. Due to timing and operational constraints, we are unable to provide bid-to-benchmark ratios based on February enrollment data in advance of the release of the Rate Announcement.

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

Comment: The majority of commenters stated their support for the continued implementation of the 2024 CMS-HCC model, stating it improves payment accuracy and program integrity, and helps address excess payments to MA organizations that have negatively affected taxpayers and beneficiaries. Specific examples of support included the following comments:

- Continued implementation of the revised model helps to reduce incentives for MA plans to code intensively.
- The model will improve risk adjustment across the industry and promote more responsible and equitable risk adjustment practices.
- Commenters stated their appreciation for CMS efforts to address what they refer to as upcoding.
- Commenters noted that the updated model is a first step to address "upcoding" and "overpayments," but more reforms are needed.

Response: We thank the commenters for their support. We agree that continuing to move to the 2024 CMS-HCC model will improve payment accuracy to MA plans and that updating the risk adjustment model is an essential part of CMS' duty to effectively run the MA program and be a steward of the Medicare program.

Comment: Some commenters recommended CMS stop or delay the three-year phase-in of the 2024 CMS-HCC risk adjustment model, so there could be more time to assess and understand it and make modifications.

Response: The three-year phase in of the 2024 CMS-HCC risk adjustment model is consistent with how CMS has approached other instances in which model updates have been phased in over time (e.g., the 2014 model was phased in over three years and the 21st Century Cures Act model requirements were phased in over four years, with the final model adopted in the CY 2020 Rate Announcement and phased in over three years). CMS appreciates the concerns raised by the commenters on the timeline for the implementation of the updated risk adjustment model. However, it is important to maintain or improve the accuracy of the risk adjustment model by updating it to reflect more recent relative costs, treatment and utilization patterns, and coding practices. We have previously noted that as a model ages and is used to predict expenditures for more recent enrollees in MA plans, that predictive accuracy begins to decline. Delaying the phase in of a risk adjustment model that is based on more recent underlying data will prolong the use of an older risk adjustment model that, though still accurate according to CMS' measures (i.e., having a predictive ratio between 0.90 and 1.10), is waning in its ability to predict current costs. For CY 2025, risk scores will be calculated as the sum of 67 percent of the risk score calculated using the updated 2024 CMS-HCC risk adjustment model with 33 percent of the risk score calculated using the previous 2020 CMS-HCC risk adjustment model. For 2026, we expect that 100 percent of the risk scores will be calculated using the updated model.

Comment: Some commenters requested that CMS provide at least 60-day notice for changes to the risk adjustment model. Another commenter recommended that any major risk adjustment model changes should be finalized two years before implementation to allow time for plans and providers to make necessary operational changes.

Response: We acknowledge the commenters' request for an extended comment period. Per section 1853(b)(2) of the Act, the Advance Notice of proposed changes to the methodology and assumptions used to determine annual MA capitation rates and the risk and other factors used in adjusting MA capitation rates under section 1853(a)(1)(C) is required to have a minimum 30-day comment period. The CY 2025 Advance Notice was released on January 31st, 2024, and comments were accepted through 6 PM Eastern Time on Friday March 1, 2024 (30 days). The statutory requirement for a 60-day comment period applied only to proposals to implement certain changes to the CMS-HCC model (based on section 1853(a)(1)(I) of the Act), in accordance with requirements in the 21st Century Cures Act (Pub.L. 114-255).

CMS believes that the period provided for comments on the CY 2025 Advance Notice is sufficient. In setting these timelines, we seek to achieve multiple goals, including providing the statutory-required amount of time for public comment while also releasing the Advance Notice using more current data to calibrate the model and ensuring that the Rate Announcement is published by the statutory deadline. We provided the public with sufficient information to review the proposals since we informed the industry that the evaluation to reclassify the model was underway as far back as 2018 and we provided a number of resources to evaluate the updated

model. Further, the updates proposed last year are in line with typical model updates for which CMS has provided a similar or shorter comment period per the existing statutory requirement at the time.

Comment: Some commenters stated that the updated model has impacted care delivery and the quality of care and will continue to do so as it is phased in. Many of these commenters expressed concerns regarding various ICD-10 codes that no longer map to HCCs in the model, as well as some of the specific clinical areas that are not included in the new CMS-HCC risk adjustment model, and expressed belief that these changes are directly affecting both physician payments from MA plans and patient care. Some commenters also believe that the model has resulted in negative clinical outcomes for particularly vulnerable populations. A few commenters expressed concern of possible unintended consequences to patient care that may occur due to changes in clinician coding practices. Commenters highlighted specific conditions as areas of concern (which were addressed in specific responses in the CY 2024 Rate Announcement).

Response: MA organizations are required, by their contracts with CMS and section 1852(a) of the Act, to furnish medically necessary Part A and Part B benefits to their enrollees. The risk adjustment model used for MA payment is not designed to drive clinical behavior to look for specific conditions or to be the sole or primary purpose for MA organizations or health care providers to identify and treat conditions that are potential precursors to adverse medical events or complicating factors in the identification and treatment of other conditions. Because MA organizations are at financial risk for the care of their enrollees, changes in the risk adjustment model do not change the fundamental incentive in a capitated payment system to reduce morbidity and mortality by identifying and treating early stages of disease. MA organizations submit bids to CMS that are based on the revenue needed to cover the expected per beneficiary costs of their enrollee population. Risk adjustment is used to adjust plan bids and calculate payment based on health status and demographic characteristics such that plans are paid more for beneficiaries predicted to have higher costs. To accurately predict the likely relative cost of each beneficiary, it is important to include in the risk adjustment model those diagnoses and conditions that are reliable predictors of future costs and exclude those that are unreliable predictors of future costs. For the 2024 CMS-HCC model, CMS undertook a comprehensive and thoughtful process, informed by clinical input, to determine the diagnoses and conditions for inclusion. As a result, the new model better directs resources to plans with beneficiaries with higher health care needs.

The CMS-HCC reclassification involved revising condition categories – including adding, deleting, and reconfiguring categories and clinical hierarchies, and freshly considering which categories are included in the payment model. The goal was to improve predictive ability, to better account for current disease patterns, treatment methods and costs, and diagnosis and coding practices. The resulting model classifies the ~74,000 ICD-10-CM codes into 266 CMS-

HCCs, 115 of which are included in the 2024 CMS-HCC payment model. This increase in condition categories from the 2020 CMS-HCC model (204 CMS-HCCs; 86 in payment) is due to the greater level of detail in ICD-10-CM diagnosis codes, allowing for the development of HCCs with increased clinical specificity and validity that better capture clinical and cost differences between conditions. In aggregate, the 2024 CMS-HCC model contains approximately 20 percent fewer ICD-10-CM codes than the 2020 CMS-HCC model. This resulted from the removal of diagnoses in accordance with CMS' risk adjustment principles, evaluated based on (1) empirical data including frequency, sample size, associated expenditures (e.g., overpredicted under the current model HCC); (2) clinical specificity and salience; (3) reliability to predict 86 prospective costs (including conditions that represent side effects of medical or drug treatment rather than underlying health status risk); and (4) variable diagnosis or reporting (based on empirical evidence or clinical input). Further discussion regarding the reclassification process can be found in the CY 2024 Rate Announcement.

Comment: A few commenters stated concerns that the Fact Sheet released with the CY 2025 Advance Notice did not discuss the methodology, assumptions, and data used for developing the MA risk score trend. A commenter believed that not providing this additional context may lead to confusion, misinterpretation, and possibly false conclusion about the impact of the risk score trend on MA payments. Commenters requested that CMS either include the methodological details behind the MA risk score trend or stop using the risk score trend in future fact sheet and Advance Notices.

Response: Each year, CMS releases an associated Fact Sheet that shows the year-to-year percentage change in payment associated with the proposed (in the Advance Notice) or finalized (in the Rate Announcement) policies. The Fact Sheet shows the overall average impact on MA revenue, as well as the average impact of each individual update or policy proposal. As part of the impacts released in the Fact Sheet, CMS also estimates the average growth of MA risk scores in the payment year, known as the MA risk score trend. The MA risk score trend is the average increase in risk scores, not accounting for normalization and the MA coding pattern adjustment (which are included separately). The MA risk score trend is included in the Fact Sheet because it has direct bearing on MA payments and the MA revenue picture would be incomplete without it.

As discussed in the CY 2025 Advance Notice, CMS calculates the MA risk score trend by calculating MA risk scores over three prior years, then calculating the average annual change in risk scores across those three years. All three years of risk scores are calculated using the risk adjustment model(s) to be used in the upcoming payment year. This average annual change is the MA risk score trend provided in the Advance Notice and Rate Announcement Fact Sheet. The trend is an industry average and individual plans' experience will vary.

Note that the MA risk score trend has a separate impact from the impact of the risk adjustment model, which is represented in a separate row of the Fact Sheet and is based on risk score changes where the underlying data is held steady. Specifically, to measure the risk adjustment model impact CMS uses the same diagnostic and demographic information run through the current model and the model(s) for the upcoming payment years (e.g., 2020 diagnoses were used to calculate 2021 risk scores under each model to calculate the risk adjustment model impact in the Fact Sheet). The difference between the current model and payment year model(s) risk scores, accounting for differences in normalization, is represented in the risk adjustment model impact and normalization row.

By including both the risk adjustment model/normalization impact and the MA risk score trend in the Fact Sheet, the resulting impact is effectively estimating a year-over-year payment impact if diagnostic and demographic data are held steady, then further accounting for growth in risk scores in the payment year based on historical experience. Therefore, it is imperative to consider the MA risk score trend in concert with the impact of risk adjustment policy proposals to accurately predict payment impacts in the following year. It is important to note that every model has its own risk score trend.

Comment: Many commenters expressed concern that the model has and will continue to have a negative impact on certain beneficiary populations, locations, and plan types. Multiple commenters believed that the diabetes changes and model changes where diagnoses are no longer included for payment are having a negative impact on dually eligible beneficiaries and vulnerable populations (e.g., minority beneficiaries and those under the federal poverty level), or beneficiaries in urban or rural areas. Multiple commenters expressed concerns about the model's impacts on plans with high enrollment of dually eligible beneficiaries, and high-risk, chronically complex vulnerable populations (e.g., Special Needs Plans that serve dually eligible beneficiaries (D-SNPs) or beneficiaries with certain chronic diseases (C-SNPs)). Multiple commenters stated that minorities and people with low incomes make up a larger share of MA enrollees than they do in FFS, and that further implementation of the model will more negatively affect them. Some commenters cited a slower growth in the availability and enrollment in D-SNPs in 2024 compared to previous years despite phasing in the model, and others expressed concern that the negative impact of the model may disincentivize MA plans from offering C-SNPs. Commenters expressed concern about the implication for benefits that SNP beneficiaries have, such as greater access to supplemental benefits, and stated that, according to their research, the model has and will continue to have a more negative impact on SNPs compared to other MA plans, which they believe may impact beneficiary cost and access to benefits.

Response: The updates improve the accuracy of the risk adjustment model and help ensure that higher payments are available to plans that serve beneficiaries with more costly health care needs. Additionally, the updates did not change features in the CMS-HCC risk adjustment

model, first implemented in 2017, that ensure dually eligible beneficiaries have unique adjustments for every health condition based on their dual-eligibility status that result in higher payments for those conditions than non-duals. The updates also do not alter changes first implemented in 2020 that ensure that plans receive an additional increase in payment based on the number of conditions the beneficiary has.

As discussed in the CY 2024 Rate Announcement, conditions in the model are used as predictors of relative costs, not as direct reimbursement for the treatment of each condition. Plan bids project the average revenue needed to cover all Part A and B benefits, and the risk score is used to assess the relative cost of a plan's enrollee population. Further, it is the total risk score that predicts the relative cost of a beneficiary, and each factor predicts part of the costs; therefore, each relative factor cannot be assessed in isolation. If a specific HCC (or diagnosis code mapped to a specific HCC) is no longer included in the payment model, coefficients of other HCCs and demographic factors will be increased such that the model continues to predict the overall total expenditures. Because the updated model improves upon the previous model by incorporating recent costs and utilization patterns and is developed using ICD-10 codes, and because the model ensures that plans that enroll beneficiaries with higher expected costs receive higher payments, we do not agree that the continued phase-in of the model will negatively affect beneficiary costs or supplemental benefits, and care delivery.

There will be variation in the impact on risk scores depending on each beneficiary's clinical mix. All of the model updates (i.e., underlying data updates, denominator update, and ICD-10 reclassification) contribute to changes in the relative costs of conditions compared to the 2020 CMS-HCC model previously used, and therefore changes to the resulting risk scores. Beneficiary risk scores or plan average risk scores may change depending on an individual beneficiary's combination of diagnoses or the clinical profile of a plan's enrollee population.

Comment: A few commenters stated their concern about the impact of the model on Puerto Rico. These commenters stated that the proposed model will have the largest negative effect on Puerto Rico due to the territory's very high MA penetration, poverty levels, and higher than national average prevalence rates for diabetes, mental health disorders, and congestive heart failure. A commenter recommended CMS include adjustments based on ADI when identifying benchmark rates.

Response: The CMS-HCC model is a national model, including large subgroup segments that capture national variation in costs between the segmented populations. The goal of risk adjusted payments is to pay accurately using the appropriate relative risk for a beneficiary. There will be variation in the impact on risk scores depending on each beneficiary's clinical mix. All of the model updates (i.e., underlying data updates, denominator update, and ICD-10 reclassification) contribute to changes in the relative costs of conditions, and therefore changes to the resulting

risk scores. Beneficiary risk scores or plan average risk scores may change depending on individual beneficiary's combination of diagnoses or the clinical profile of a plan's enrollee population.

Conditions in the model are used as predictors of relative costs, not as direct reimbursement for each condition. As discussed previously, the updated model improves predictive accuracy and helps ensure that higher payments are available to plans that serve beneficiaries with greater expected health care costs and, therefore, we do not agree that the updated model has disproportionately negatively affected beneficiaries depending on their geographic region.

We understand that geographically Puerto Rico has a high percentage of beneficiaries with risk scores calculated using the full benefit dual segment. As previously stated, CMS has observed that, on average, predicted risk for dually eligible populations are higher than non-dually eligible enrolled beneficiaries. The risk scores for dually eligible beneficiaries decrease less, compared to the risk scores for non-dual eligibles when taking into account the risk adjustment model and normalization impact as well as the MA risk score trend. When considering payment, the full scope of contributing factors must be considered. MA plans submit bids to CMS that request the total revenue needed to cover the expected per beneficiary costs of their enrollee population. The purpose of the model is to calculate risk scores (that are used in calculating payments made to plans) to take into account differences in expected costs for their enrollees and to increase or lower payment based on the relative expected costs. Risk adjustment is used to adjust plan bids and calculate payments based on health status and demographic characteristics such that plans are paid more for beneficiaries predicted to have higher costs due to increased risk. Further, individual coefficients do not represent complete costs for expected expenditures related to a condition, but only the average increase in the overall predicted costs for a beneficiary with that condition relative to other conditions used for payment in the model. Rather, the total relative cost of a beneficiary, or a group of beneficiaries, is represented by the total risk score.

Comment: Commenters stated their concern that the model is negatively impacting providers engaged in value-based payment models. A few commenters expressed concern that cuts to MA payments will exacerbate provider shortages.

Response: CMS thanks the commenters for expressing their concerns. Per section 1854(a)(6)(B)(iii) of the Act, CMS is prohibited from interfering in payment arrangements between MA organizations and providers with which they contract by requiring specific price structures for payment. The purpose of the risk adjustment model is to predict the overall relative expected expenditures for beneficiaries for purposes of paying MA organizations accurately and fairly for the relative expected costs for the enrollees in their plans. MA organizations in turn develop provider networks and negotiate payment arrangements with participating providers for the delivery of covered services to enrollees.

MA organizations are required to cover all Medicare Part A and Part B services (subject to limited exclusions), maintain adequate networks, and provide quality care. They are responsible for determining their own revenue needs to cover these services. An updated risk adjustment model is intended to more appropriately pay plans that are enrolling a sicker population. In paying plans a capitated payment, CMS contracts with MA organizations for them to provide coverage of – by furnishing, arranging for, or making payment for – these benefits. The nature of the MA program, by using capitated payments, allowing MA plans to use a portion of savings when they bid below the benchmark to furnish additional benefits, and transferring full financial risk to MA plans, incentivizes MA organizations to develop cost efficiencies in care provision. Reducing morbidity and mortality by catching early stages of disease in an inherent expectation of a capitated managed care system.

Section 1852 of the Act requires MA plans to cover Medicare Part A and B benefits (subject to limited exclusions) for their enrollees and that when the MA plan uses a network of providers and limits coverage to those providers, the MA plan must ensure that covered benefits are available and accessible to enrollees. The CMS-HCC risk model used for risk adjusting payments to MA plans does not limit or change these requirements related to coverage. We expect that MA organizations will renegotiate or revise the payment arrangements they have with their contracted providers as necessary to ensure that the MA plan continues to make benefits available and accessible for enrollees.

The risk adjustment model is not intended to incentivize (or disincentivize) any particular care modality. This is illustrated by, for example, not weighting diagnoses by site of care. Another example is allowing costs to flow to demographic variables, which allows some portion of plan payments to be paid regardless of disease state and thereby provide funds for a wide range of prevention and intervention approaches, as well as to cover treatment of acute and lower-severity chronic conditions not included in the risk-adjustment model. Finally, and to reiterate, by using more recent data in calibrating the model, coefficients are recalculated, and conditions that might be relatively more costly than they were in previous years, will result in higher risk scores for beneficiaries with such conditions. The 2020 CMS-HCC risk adjustment model was calibrated using diagnosis from 2014 and costs from 2015 and has a 2015 denominator whereas the 2024 CMS-HCC risk adjustment model was calibrated using diagnoses from 2018 and costs from 2019 and has a 2020 denominator.

Comment: A commenter expressed concern that the continued phase in of the model requires providers to modify their practices related to coding and diagnosis. They requested CMS conduct an educational campaign throughout the model phase-in to support provider understanding of the model.

Response: While CMS engages with stakeholders on a regular basis through various lines of communication, physicians should not adjust their diagnostic or coding practices as we phase-in the model. Physicians should not be diagnosing and coding based off risk adjustment, rather, they should accurately diagnose and code for patients' diagnoses using ICD coding guidelines.

Comment: Commenters suggested several proposals for model revisions including:

- Many commenters suggested the removal of health risk assessments and chart reviews as a source of diagnoses for risk adjustment, which they believe would help reduce overcoding practices.
- Multiple commenters requested CMS use two years of diagnostic data in risk adjustment to reduce the impact of coding differences between MA and FFS.
- Several commenters recommended CMS switch to a model based on MA encounter data so the model does not rely on FFS data.

Response: We appreciate the extensive and thoughtful comments and feedback we received on improving the CMS-HCC risk adjustment model.

Comment: A commenter expressed concern that CMS has not fully accounted for the model impact. The commenter requested CMS provide methodology for calculating the -4.44 percent model phase-in impact noted in the CY 2025 Advance Notice.

Response: As explained in our FAQ #11 for the CY 2025 Advance Notice, [9] the model impact in the Fact Sheet included with the CY 2025 Advance Notice and the CY 2025 Rate Announcement is the net of two impacts: the "raw" (unnormalized) model impact – the difference between risk scores for the same population under the older and newer model – and the impact of the updated normalization factor. The combined impact accounts for the continued phase in of the 2024 CMS-HCC model. By combining the raw model impact with the impact of the updated normalization factor on risk scores, we are accounting for the trend in risk scores that occur between the denominator and the payment year. We note that the -4.44 percent is the difference in raw risk scores, and reflects the phase in of the new model, whereby we are using 33 percent of the risk scores under the 2024 CMS-HCC model in CY 2024, and 67 percent of the risk scores under the 2024 model in CY 2025 – so a change of 34 percentage points. As with every update of the risk adjustment model, the impact on each plan can vary, depending on the clinical profiles of their enrollees.

[9] Refer to CMS' CY 2025 Advance Notice Fact Sheet.

***CMS-HCC Risk Adjustment Model for PACE organizations for CY 2025***

Comment: Of the commenters who addressed the continued use of the 2017 CMS-HCC model, all supported the use of the 2017 CMS-HCC model to calculate PACE organization risk scores. While these commenters supported the use of the 2017 CMS-HCC model, they also expressed concerns about the model (addressed in the comments and responses below).

Response: CMS appreciates the support. CMS will continue to use the 2017 CMS-HCC model to calculate risk scores in CY 2025.

Comment: Commenters expressed general concern that PACE payments under the current risk adjustment methodology continue to fail to recognize the costs of care associated with their complex population and requested that CMS transition PACE to the same model being used to calculate risk scores for MA organizations, commenting that:

- The 2024 CMS-HCC risk model includes dementia (and other chronic condition HCCs) that have a high prevalence in the PACE population and are missing in the 2017 CMS-HCC model. As a result, these commenters believe the model results in systemically low payments to PACE organizations and threatens their ability to provide integrated, quality care to this frail, often dual-eligible population.
- The use of frailty adjusters under the 2017 CMS-HCC model is not seen as a reliable or adequate substitute for recognizing the risk faced by PACE organizations in caring for their participants with dementia.
- The lack of alignment between MA and PACE may exacerbate payment disparities by failing to recognize the cost of care for complex PACE population, further aggravated by the fact that the 2024 CMS-HCC model is calibrated on ICD-10 diagnostic codes whereas the 2017 CMS-HCC model continues to be calibrated on ICD-9 codes.
- The standard software and systems MA and PACE organizations use to generate data and information are no longer supporting ICD-9 codes and RAPS files, potentially leading to inaccurate or non-comprehensive data submissions.

Response: CMS will continue using the 2017 CMS-HCC risk adjustment model for risk adjusted payment to PACE organizations for CY 2025. The 2017 CMS-HCC risk adjustment model was first adopted for PACE in the 2022 Rate Announcement.[10] As CMS has noted in the past, we recognize that using distinct HCCs to calibrate separate models for PACE and MA may result in differences in predicted risk for individual beneficiaries, however, we note again that the costs associated with conditions that are not in the 2017 CMS-HCC risk adjustment model for payment, such as dementia, are predicted by comorbid conditions and demographic factors. To

[10] Refer to Section I. of the CY 2022 Rate Announcement.

the extent that these costs are not predicted by the model, they are reflected in the frailty factors. While the 2017 CMS-HCC model was calibrated using ICD-9 codes, risk adjustment submissions and risk score calculation converted to the use of ICD-10 codes during the industry conversion in October 2015. Therefore, CMS updated the diagnosis to HCC/RxHCC mappings for all the models, including those used for PACE to ICD-10. CMS provides risk adjustment model software for all models used to calculate PACE risk scores for each model run. In addition, CMS releases the diagnosis to HCC/RxHCC ICD-10 mappings for each model run.

As CMS noted in the CY 2024 Rate Announcement,[11] because we do not have a complete diagnostic profile for their members in the encounter data system, we cannot rely solely on encounter data to calculate PACE risk scores and, instead, use diagnoses from encounter data as a supplement to RAPS data when calculating risk scores for payment using the 2017 CMS-HCC risk adjustment model. We understand the desire to move PACE organizations to the updated model calibrated on ICD-10 codes. However, because the 2024 CMS-HCC risk adjustment model was calibrated using FFS diagnoses that were selected using the filtering method that is used for encounter data, this model is intended to calculate risk scores using diagnoses submitted on encounter data records and FFS claims (for beneficiaries who switch from FFS to MA) filtered in the same manner as encounter data records. Since we do not have complete encounter data from PACE organizations, we are not calculating PACE beneficiary risk scores using diagnoses solely from encounter data and FFS claims (in contrast to the approach to calculating Non-PACE beneficiary risk scores), and we cannot implement the 2024 CMS-HCC risk adjustment model for PACE at this time.

In January of 2024, CMS released technical instructions to PACE organizations on the submission of risk adjustment data to the EDS (that is, encounter data) for PACE center services for which a claim is not generated. CMS also provided the instruction to begin transitioning all PACE organizations to submitting risk adjustment data to the EDS rather than RAPS. As noted in the CY 2025 Advance Notice,[12] because of our findings from stakeholder engagement and analysis, CMS believes that calculating PACE risk scores solely using diagnoses from encounter data and FFS claims is achievable soon. We remain committed to working closely with PACE organizations to support their transition to EDS submissions and the implementation of the updated risk adjustment model for PACE. We intend to provide ample support and guidance to make this transition as straightforward as possible.

[11] Refer to Section J. of the CY 2024 Rate Announcement.
[12] Refer to Section L1. of the CY 2025 Advance Notice.

**Section K. ESRD Risk Adjustment Models for CY 2025**

***For PACE Organizations***

CMS did not receive comments on the CMS-HCC ESRD risk adjustment models for PACE organizations for CY 2025. CMS will continue to calculate risk scores for payment of beneficiaries with ESRD in PACE organizations using the CY 2019 CMS-HCC ESRD risk adjustment models as proposed in the CY 2025 Advance Notice.

***For Non-PACE Organizations***

Comment: One commenter supported the continued use of the CY 2023 CMS-HCC ESRD Models for 2025.

Response: Thank you for your comment. For CY 2025, we will continue to calculate 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 CY 2025 Advance Notice.

Comment: Several commenters expressed concern about interaction of the Part B transition of oral-only ESRD drugs between the Part D and ESRD models. Specifically, a few commenters noted that CMS updated the Part D model to account for the Part D to Part B transition of oral-only ESRD drugs (e.g., phosphate binders) but did not update the ESRD model to account for ESRD bundled costs. Commenters requested coordination amongst CMS policy teams on the timeline and implementation of incorporating oral-only drugs into the ESRD PPS bundled payment. A couple of commenters stated that when the transition occurs, CMS should also update the ESRD risk adjustment models to account for the cost of phosphate binders. Commenters expressed concern about inadequate reimbursement rates if the costs of drugs in the ESRD PPS bundled payment is not accounted for in the ESRD model.

Response: Thank you for your comments. We appreciate the request for model updates and coordination. CMS acknowledges the concern that the phosphate binder costs are not included in the current ESRD risk model. We note that the costs for the final reconciled payment years available for model calibration do not include phosphate binder coverage. Therefore, we will continue to analyze and consider these recommendations as we evaluate ESRD model calibration updates in the future.

Comment: One commenter believes that the ESRD model does not appropriately reflect the high costs MA plans face in providing care and coverage for ESRD enrollees, and that CMS should revise the model to ensure MA payments are adequate to ensure access to care.

Response: Thank you for your comment. CMS implemented the ESRD model to improve accuracy for enrollees with ESRD, including those in dialysis status, transplant status, and in

post-graft status in 2005 specifically to address this issue. We have updated the model over the years to reflect more recent cost and utilization trends, as well as clinical updates to improve risk adjustment payments for beneficiaries with ESRD. The risk scores generated by the model predict beneficiaries' expected health care costs relative to the average beneficiary, and are used to calculate payments by adjusting the appropriate ESRD rate. We appreciate the comment and acknowledge the commenter's concerns and will continue to evaluate the ESRD risk adjustment model in the future.

**Section L. Frailty Adjustment for PACE Organizations and FIDE SNPs**

***Frailty for FIDE SNPs***

Comment: One commenter specifically expressed support for the use of the full Medicaid frailty factors to calculate FIDE SNP frailty scores in CY 2025.

Response: CMS appreciates the support. As proposed, CMS will use only the full Medicaid frailty factors to calculate FIDE SNP frailty scores for FIDE SNP enrollees in CY 2025.

Comment: Commenters expressed concerns regarding a number of aspects of frailty they believe result in underpayment for beneficiaries with the highest need including general concerns about the decline in frailty scores, the disproportionate impacts of lower frailty scores on vulnerable and high-need populations (e.g., dual-eligible enrollees) due to payment decreases, concerns about low response rates, and concerns that response rate shifts to the lower activities of daily living (ADLs) groups may result in survey bias. These commenters made a variety of recommendations, including:

- *Adjustments*. Several commenters recommended that CMS adjust frailty scores to account for the under-estimation of frailty in prior years, contract-level adjustments to frailty factors to account for response rate bias, adjust the model coefficients and results to account for potential bias produced by uneven response rates by ADL group, institute measures that would phase-in/out frailty to allow application in years where a plan does not meet the PACE minimum.
- *Frailty score source*. A couple of commenters recommended that CMS evaluate other potential sources to assess frailty, such as state-level assessment data.
- *Survey protocol modifications*. A couple of commenters recommended modifications to the current survey protocol such as increasing the number of members being surveyed, improving HOS/HOS-M vendor capabilities and competition to field surveys, that CMS consider allowing FIDE-SNPs to survey only those members who are at a nursing home level of care, and increased data sharing between CMS, health plans, and the HOS/HOS-M survey vendor to ensure the surveyed and responding population is representative of the full population.

- *Application to expanded beneficiaries*. Some commenters recommended CMS apply frailty to additional populations such as working with Congress to provide Highly Integrated Dual Eligible Special Needs Plans (HIDE SNPs) access to the frailty adjustment as accessed by FIDE SNPs, and that CMS decouple the FIDE SNP requirement from PACE to apply the frailty adjustment to the under 55 population.

Response: By law, CMS must use the same payment methodology for all enrollees in MA plans, including Special Needs Plans (SNPs), except as explicitly provided for in statute. Section 1853(a)(1)(B)(iv) of the Act authorizes CMS to make frailty-adjusted payments only to certain dual SNPs, which must have similar average levels of frailty as the PACE program. Thus, CMS cannot make frailty payments to any SNP that does not meet these criteria without implementing frailty payments program wide. CMS has explored ways of incorporating frailty into the risk adjustment model in order to account for frailty when making risk adjusted payments to all plans (including HIDE SNPs) without limitations on age and found challenges with a number of approaches.[13] Because the frailty factors are calculated using the residual of the CMS-HCC risk adjustment model (the difference between the predicted expenditure amounts and the actual expenditure amounts), and frailty scores have an average value of zero, the application of a frailty adjustment to all MA plans would result in many plans receiving a negative frailty adjustment.

The HOS has had considerable validation of its ability to accurately capture functional limitations and other health related characteristics. For example, see "Patients' Self-report of Diseases in the Medicare Health Outcomes Survey Based on Comparisons with Linked Survey and Medical Data from the Veterans Health Administration" (Journal of Ambulatory Care Management, 2008 by Miller, et. al.). While we understand that surveys can have operational challenges in administration, as noted in prior Rate Announcements (e.g., 2019), we believe that the HOS and HOS-M continue to provide an accurate and representative measurement of frailty at the plan level because ADL data are collected to calculate frailty scores in the same manner that are collected and used to calculate frailty factors for model calibration (i.e., limitations in activities of daily living collected from self-reported surveys). In addition, data are collected consistently across respondents, such that frailty scores are calculated using data collected in the same manner across plans, thereby allowing survey results to be compared across plans and relative to PACE (a requirement for determining whether FIDE SNPs receive a frailty adjustment in payment) and thus resulting in frailty payments that are comparable.

As noted in the CY 2025 Advance Notice[14] CMS is continuing to evaluate the underlying patterns driving the changes in the 2024 CMS-HCC model frailty factors.

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[13] Refer to the studies discussed in Section K. of the CY 2023 Rate Announcement.

[14] Refer to Section I. of the CY 2025 Advance Notice.

Comment: A couple of commenters requested that CMS provide additional information. One commenter requested that CMS release additional information to support bidding submissions. Specifically, the commenter requested the distribution of survey responses corresponding to the PACE minimum for the last several years to support bidding given what they believe is year-over-year instability. In addition, they requested that in future years, CMS include the distribution used to calculate the PACE minimum as a standard part of the Advance Notice and/or Rate Announcement, believing the historic PACE distribution would help plans understand the variation of the minimum from year-to-year and use that information to better project the likelihood of payment. Another commenter requested that CMS clarify how using the updated 2024 CMS-HCC model will impact the FIDE SNPs' frailty adjustment calculations, specifically expressing concern that there is a negative impact on FIDE-SNPs as frailty scores have declined over time with the population served most likely to have the deleted or changed 2024 CMS-HCC model HCC groups.

Response: Every year CMS releases the distribution of ADL limitations across all PACE organizations based on the most current HOS-M data in the annual HPMS memo regarding participation in HOS/HOS-M for MA organizations planning to sponsor FIDE SNPs.[15] In addition, the PACE minimum is provided every year via HPMS with the release of the payment year frailty scores.[16] CMS will consider what additional information can be provided in the future to assist FIDE SNPs in estimating frailty for their bid submissions.

CMS understands the concern regarding decreases in frailty scores. CMS releases the survey results and ADL distribution to each FIDE SNP that elects to field the survey annually. Using this information and the frailty factors corresponding to each payment year, FIDE SNPs can analyze their ADL distribution and frailty factor impact over time. We note that we must implement frailty factors that align with the CMS-HCC risk adjustment model to be used in payment, since the frailty factors are calculated by predicting costs that are not captured by the specific CMS-HCC risk adjustment model used for payment. When the risk adjustment models are updated and better predict beneficiary cost patterns, there is less residual cost to attribute to the frailty factors used in risk adjustment payments in the payment year. As a result, frailty factors can be lower for the 2024 CMS-HCC risk model relative to the older model. As noted in the CY 2025 Advance Notice,[17] CMS is continuing to evaluate the underlying patterns driving the changes in the 2024 CMS-HCC model frailty factors.

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[15] For the most recent version of this memo, see: Participation in 2024 HOS/HOS-M for MA Organizations Planning to Sponsor FIDE SNPs in 2025 – Response Needed by Wednesday, February 28, 2024.

[16] For the most recent version of this memo, see: 2023 Frailty Scores and 2022 Health Outcomes Survey (HOS) or Health Outcomes Survey Modified (HOS-M) Activities of Daily Living (ADLs) Results.

[17] Refer to Section I. of the CY 2025 Advance Notice.

***Frailty for PACE Organizations***

Comment: Commenters supported the continued use of the frailty factors associated with the 2017 CMS-HCC model to calculate frailty scores for CY 2025.

Response: CMS appreciates the support. CMS will continue to use the frailty factors associated with the 2017 CMS-HCC model to calculate frailty scores for PACE organizations in CY 2025.

Comment: Commenters expressed concerns with using the HOS-M survey to estimate frailty because of low response rates (especially amongst those with dementia), and that reliance on the HOS-M for frailty adjustment does not consider the challenges faced by people with dementia in completing the survey. The commenters urged that, if dementia could not be included in the 2017 CMS-HCC risk adjustment model used to pay PACE organizations for CY 2025, CMS modify the CY 2024 HOS-M survey administration protocol to allow PACE organizations to proactively offer completion assistance for the survey to their participants living with dementia to increase the likelihood that they are adequately represented in the survey's results. Commenters stated they estimate 50 percent of PACE enrollees have dementia, and they believe the HOS-M is not a reliable or adequate substitute for recognizing the risk faced by PACE organizations in caring for their participants living with dementia.

Response: Because the CMS-HCC risk adjustment model predicts total expenditures for Part A and Part B benefits, for beneficiaries with conditions such as dementia that are not directly incorporated in the 2017 CMS-HCC model, the associated costs can be predicted by comorbid conditions and demographic factors that are included in the model. To the extent that these costs are not predicted by the model, they are likely to be reflected in the frailty factors. CMS estimates frailty factors to explain additional costs not explained by diagnoses in the CMS-HCC model used to calculate risk adjusted payments for the organization in the payment year. CMS calibrates the frailty factors by regressing the residual, or unexplained costs from the CMS-HCC risk adjustment model, onto counts of ADLs. Although total costs are included in the calibration of the 2017 CMS-HCC risk adjustment model, and the associated frailty factors help predict overall costs where diagnoses are not fully predictive, results for individual organizations may differ due to differences between the sample used for model calibration and the populations enrolled in individual plans.

CMS acknowledges the concerns related to the response rates for the HOS-M for PACE participants, particularly among participants with dementia. The responses from this survey are used to determine a beneficiary's limitations in ADLs that are accounted for in the calculation of

a contract's frailty score. We collect survey data in a consistent manner for all PACE organizations, as this helps to ensure equitable frailty results for payment. In addition, ADL data are collected to calculate frailty scores in the same manner that these data are collected and used to calculate frailty factors for model calibration (i.e., limitations in activities of daily living collected from self-reported surveys). Permitting variation in how the survey is administered for participants with specific conditions may disproportionately affect frailty scores for certain organizations, depending on what proportion of an organization's participants have that condition and which organizations provide the assistance. There are existing proxy allowances in the survey administration protocol. For the HOS-M, a proxy response is at the discretion of the beneficiary, but PACE staff may inform the family member or caregiver of their right to request a proxy if participants with dementia need assistance completing the survey.

**Section M. MA Coding Pattern Difference Adjustment**

Comment: Several commenters supported CMS' proposed 5.9 percent coding pattern adjustment for CY 2025.

Response: CMS appreciates the support of the commenters. CMS is finalizing the proposed adjustment of 5.9 percent for CY 2025.

Comment: Several commenters opposed CMS' proposed 5.9 percent 2025 coding pattern adjustment and provided alternative recommendations to the statutory minimum coding pattern adjustment of 5.9 percent, as summarized below:

Higher Adjustment Factor: Several commenters recommended a higher adjustment factor than the statutory minimum, which they state is inadequate to adjust for differential patterns of coding between MA and FFS. Commenters expressed concern that the statutory minimum does not account for the full impact of coding pattern differences, and multiple commenters highlighted analyses from MedPAC that the coding adjustment factor should be several percentage points higher. These commenters stated their belief that excess spending is accelerating the depletion of the Medicare Trust Funds and the potential savings from fully accounting for the coding pattern differential would increase solvency of the Trust Funds. A few commenters that recommended a higher coding pattern adjustment expressed concern that the current application of the minimum adjustment and the risk adjustment model incentivize plan sponsors to code their enrollees with as many conditions as possible, driving up payment rates.

Specific Methodological Recommendations:

- Demographic Estimate of Coding Intensity (DECI). One commenter recommended the incorporation of the DECI method to calculate a coding pattern adjustment factor. Under

the assumption that MA does not receive adverse or favorable selection relative to FFS in terms of health status, the recommended DECI method controls for demographics, estimating the coding pattern adjustment by comparing MA risk relative to FFS risk using the CMS-HCC risk adjustment model, and comparing that relationship against MA risk versus FFS risk using the Adjusted Average Per Capita Cost (AAPCC) model that is based on demographics only and was used in payment prior to 2000.

- Targeted Approaches:
    - General comments supporting targeted approaches. Several commenters expressed concern that applying an across-the-board coding pattern adjustment could negatively affect smaller plans who do not engage in upcoding. A few commenters recommended targeted approaches, because of their concern that certain MA organizations code much more aggressively than others with higher levels of coding intensity due to various structural payment incentives, including payments between MA organizations and their contracted providers. Other commenters stated their concern about the current application of the factor because it does not adequately adjust for risk score increases above the average, and disadvantages plans serving primarily low-income and historically underserved communities that have less administrative resources to focus on diagnosis coding.
    - Segmented/tiered approach. Several commenters suggested a segmented or tiered approach to coding pattern adjustments that recognizes different levels of coding patterns among plans, such that the lowest coding factor is applied to lower coding plans while the highest factor is applied to higher coding plans. One commenter suggested that CMS investigate whether such an approach would discourage over coding without penalizing plans that appropriately adhere to coding guidelines.
    - Contract-specific approach. A few commenters recommended tailoring the MA coding pattern adjustment to the relative level of coding intensity seen in individual MA contracts – rather than the across-the-board coding pattern adjustment that CMS applies today to all MA contracts. A few commenters believe that CMS should consider increasing the MA coding pattern adjustment for all contracts and consider using its statutory authority to vary the coding pattern adjustment by contract.

A few commenters had recommendations to calibrate the CMS-HCC risk model using different data to address coding pattern differences between MA and FFS. One commenter recommended a multipronged approach to addressing coding pattern differences in MA and FFS. Their

recommendation included three parts: 1) develop a risk adjustment model that uses two years of FFS and MA diagnostic data; 2) exclude diagnoses that are documented only on health risk assessments from either FFS or MA; and then 3) apply a coding adjustment that fully accounts for the remaining differences in coding between FFS Medicare and MA plans.

One commenter stated that CMS should work with Congress to reduce the statutory minimum coding pattern adjustment given the Prinicple-10 based updates made to the 2024 CMS-HCC model and another commenter suggested a population adjuster that could help ensure the coding intensity adjustment accounts for the vast differences between populations.

Response: Section 1853(a)(1)(C)(ii) of the Act establishes a minimum MA coding pattern adjustment, which was originally adopted beginning with 2014 payment. The current statutory minimum coding pattern adjustment is 5.9 percent. In accordance with statute, CMS analyzes coding pattern differences and determines what the coding pattern adjustment factor should be on an annual basis. We have found that the minimum adjustment is sufficient to reflect differences in coding patterns between MA plans and providers under FFS Parts A and B. CMS continues to believe that applying a uniform adjustment is an appropriate approach. Therefore, we are finalizing our proposed MA coding pattern adjustment factor for CY 2025.

We appreciate the extensive and thoughtful comments and feedback we received on this proposal. Ensuring that the coding pattern adjustment policy appropriately addresses differences in coding patterns between the FFS program and MA is essential, and we will consider these recommendations in the development of future proposals regarding the coding pattern adjustment.

Comment: One commenter requested sufficient time and information to comment on any potential changes to the MA coding pattern adjustment in the future.

Response: CMS appreciates the comment. Section 1853(b)(2) of the Act requires that CMS provide notice of proposed changes in the methodology and assumptions for setting MA capitation rates and risk and other factors used to adjust the capitation payments, with a comment period of at least 30 days to comment on the proposed changes. We will continue to consider additional ways in which we can engage with stakeholders should we consider changes to the MA coding pattern adjustment.

Comment: One commenter suggested that CMS utilize the RADV audits on health plans to identify potential upcoding based on significant variation from risk adjustment averages.

Response: We appreciate the suggestion. The coding pattern adjustment is applied to account for the impact on MA risk scores of the differential coding patterns between MA and FFS, whereas the primary goal of the RADV audits is to address improper payments to MA organizations.

Comment: A few commenters recommended making fundamental changes to the CMS-HCC Risk Adjustment model that prevents gaming and helps to drive high-quality and equitable healthcare in the long run, such as using two years of traditional Medicare and MA diagnostic data for calculating MA risk adjusted payments.

Response: We appreciate commenters' feedback. CMS diligently updates the CMS-HCC Risk Adjustment model to account for several changes such as updated data years, clinical revisions, and ICD-10 changes, and will continue to update the CMS-HCC model to drive high-quality and equitable healthcare.

Comment: A few commenters recommended that CMS limit the use of chart reviews and health risk assessments by MA plans to eliminate potential upcoding.

Response: We appreciate the recommendation to limit the use of chart reviews and health risk assessments in risk adjustment. CMS has issued guidance regarding health risk assessments and chart review records in recent years to ensure they are being utilized appropriately.[18] We understand commenters' concerns and will keep them in consideration in the future.

**Section N. Normalization Factors for the CMS-HCC Risk Adjustment Models**

Comment: Multiple commenters supported transitioning to a multiple linear regression methodology that incorporates FFS risk scores from the most current five years of average FFS risk scores available (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. A commenter stated support for the proposal saying that a more fundamental methodological change is needed. The commenter also stated that projecting forward from the denominator year to the payment year under a linear slope methodology is inappropriate given the impact the COVID-19 pandemic had on FFS risk scores in 2021 and 2022. A few commenters believe that the multiple linear regression methodology better captures more recent demographic changes in the Medicare population because of the incorporation of more recent data. Another commenter stated that they largely agree with and support CMS' proposed methodology, but they did have concerns with the proposed use of data from only 2019 through 2023 for the regression analysis.

Response: CMS appreciates the support of the commenters. CMS is finalizing the methodology for the normalization factors for the CMS-HCC and CMS-HCC ESRD risk adjustment models as proposed.

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[18] Refer to the CY 2016 Rate Announcement; Medicare Managed Care Manual; and April 28, 2018 HPMS memo entitled, "Additional Guidance for Chart Review Record (CRR) Submissions."

Comment: The majority of the commenters opposed the Part C normalization factor methodology as proposed. This includes many commenters who supported using a multiple linear regression methodology but with recommended changes and a smaller subset of commenters who opposed deviating from the historical linear slope methodology altogether.

Most of these commenters believe CMS is overstating the CY 2025 Part C normalization factor by putting too much weight on FFS risk scores from years after the onset of COVID-19 that have significant variability and not enough weight on FFS risk scores prior to the onset of the COVID-19 pandemic. Most of the commenters assumed that the future FFS risk score trend will return to pre-COVID-19 levels and this return should be accounted for in the normalization factor calculation. A commenter stated the proposed methodology would misestimate the normalization factor by 2.5 percent and that this would harm beneficiaries through higher premiums, reduced benefits, and fewer choices.

Response: CMS appreciates the feedback and concerns of the commenters. We also thank the commenters who agree with adopting a multiple linear regression methodology but also recommended adjustments. By using a multiple linear regression methodology, CMS can more appropriately take into account significant changes in the trend, as was observed with the onset of the COVID-19 pandemic when risk scores dropped significantly due to atypically low utilization. This methodology enables CMS to incorporate more recent years of data in the FFS risk score trend to reflect current risk while projecting a risk score that is reflective of what the average FFS risk score is likely to be. CMS believes that this approach is the best way to more reasonably normalize risk scores given the variability in the years after the onset of COVID-19. CMS thinks it is important to incorporate more recent years of data in the trend to reflect current risk and we must balance that with projecting a risk score that is reflective of what the average FFS risk score is likely to be in order to establish an appropriate normalization factor.

CMS accomplishes this by including a COVID-19 indicator flag in our regression inputs to differentiate risk scores that were based on diagnoses from before and after the onset of COVID-19. The inclusion of the COVID-19 indicator in the multiple linear regression allows us to incorporate all of the most current five years of FFS risk scores available by not treating all data years uniformly when it comes to their impact on the trend calculations and projections, accounting for the drop in the average FFS risk score due to COVID-19 and distinct slopes between the two time periods. We note that we are not weighting the post-COVID-19 trend more than pre-COVID-19 trends, but rather allowing the regression to recognize two distinct trends and take them into account. Previously, our projections treated each year uniformly without considering the distinct trends that exist before and after the onset of COVID-19. The inclusion of the COVID-19 indicator in our multiple linear regression methodology allows us to consider the specific influence of the pandemic by now recognizing a distinction between the trends and

risk score levels for the pre- and post-COVID-19 periods when projecting to the future year without needing to exclude any FFS risk score data.

By accounting for the impact of the pandemic on risk score trends and the actual variation in the risk scores over time in our projections we believe the multiple linear regression methodology as proposed in the CY 2025 Advance Notice produces normalization factors for CY 2025 that better fit the FFS risk score data relative to the historical linear slope approach, and results in a reasonable projection without excluding data.

In response to the commenters concerned that the risk model revisions and normalization factors will negatively impact MA revenue, CMS notes that every year we release an associated Fact Sheet that shows the year-to-year percentage change in payment associated with the proposals in the Advance Notice and the policies finalized in the Rate Announcement. The Fact Sheet for this Rate Announcement shows the overall average impact on MA revenue, accounting for all factors listed in this Rate Announcement, is expected to be a positive 3.70 percent for CY 2025. This estimate includes impacts related to the 2025 Part C normalization factor and the phasing in of the 2024 CMS-HCC model.

Comment: CMS received numerous comments containing varying individual recommendations and alternatives for CMS to consider regarding the data years used in the calculation of the normalization factors for CY 2025, which are discussed in more detail below. Many commenters believe the data years used in the proposed Part C normalization methodology will create normalization factors that are too high, thereby inappropriately lowering risk scores for CY 2025. Many of these commenters are concerned that using FFS risk scores that were previously excluded from the normalization factor calculation (e.g., 2021 and/or 2022) is inconsistent and will lead to normalization factors that are erroneously high. Some of the commenters also believe that 2021 and 2022 risk scores (based on 2020 and 2021 dates of service, respectively) are causing the proposed Part C normalization factor to represent a risk score trend that does not match historical patterns of risk score growth.

A few commenters stated that they believed that the number of years of FFS risk scores used in the proposed multiple linear regression methodology is insufficient and runs the risk of "overfit," whereby a statistical model begins to describe the random error in the data rather than the relationships between variables due to an insufficient amount of data used in the calculation. The commenters stated that the issue of overfitting is due to CMS only using five data points and because of this, the multiple linear regression methodology will not be accurate when predicting for years outside of those used in the regression (2019-2023). A number of commenters provided recommendations for adjusting the FFS data years used in the Part C normalization factor methodology trend. The recommendations included various alternatives

that involve either excluding a number of FFS risk score data years between 2020 – 2022, including data years between 2017 – 2018, and/or a combination of the two.

Many commenters believed that the average FFS risk scores are, or will begin to be, trending back toward the pre-COVID-19 rate of growth and that the post-COVID-19 trend is overly accounted for in the proposed Part C normalization factor methodology. Multiple commenters provided in-depth analysis indicating their belief that the post-COVID-19 risk score trends do not exhibit a linear relationship over time and that non-linear relationship should be accounted for in the Part C normalization factor methodology. Specifically, commenters stated that the pre-COVID-19 years reflect a linear pattern, but the post-COVID-19 period may be exhibiting more of a decelerating, curved pattern.

Response: CMS appreciates commenters' concerns regarding the data years used to calculate the Part C normalization factors for CY 2025. As stated above, CMS received a significant number of alternative recommendations from commenters about which data years to use to calculate the Part C normalization factors. There was not an industry-wide consensus; the recommended alternatives were varied, sometimes conflicting, and produced different normalization factors with varying degrees of magnitude. CMS believes that these alternatives to the data years used in determining the CY 2025 normalization factors will not provide more reasonable estimates of average 2025 FFS risk scores, and that the proposed Part C normalization factors – developed using a multiple linear regression approach with the most recent five years of data and a COVID-19 indicator, without excluding data – are better projections of the applicable average FFS risk score in 2025.

The goal of the normalization factor is to reasonably predict the FFS risk score in the payment year, thereby maintaining an average FFS risk score of 1.0 across the entire FFS population. CMS believes that the inclusion of data years prior to 2019 or exclusion of data years impacted by COVID-19 in the multiple linear regression calculation will result in a projected risk score (i.e., normalization factor) that is significantly below what the actual average FFS risk score is likely to be in 2025.

Using a linear slope method assumes a constant trend across all years whereas the multiple linear regression method with a COVID-19 indicator allows us to estimate different slopes for pre- and post-COVID-19 affected years, capturing the impact of the pandemic on FFS risk scores in our projections. Rather than calculating one slope over a five-year period to estimate the average FFS risk score in the payment year, which in recent years necessitated the exclusion of atypical FFS risk scores to estimate a reasonable projection, our multiple linear regression method considers the distinct slopes and FFS risk score levels that exist before and after the onset of COVID-19, without requiring any exclusion of recent-year risk scores. The inclusion of a

COVID-19 indicator and performing a multiple linear regression will ensure our projections align more closely with reasonable FFS risk score projections.

CMS believes that five years of FFS risk score data continues to be appropriate for the purposes of calculating normalization factors. The use of five recent years of FFS risk scores allows CMS to consider risk scores in its estimates of the normalization factors that are more likely to reflect the current state of FFS risk score growth, while smoothing some of the volatility that can occur over time. We believe that including an additional one or two years of historical FFS risk scores would place emphasis on data that do not have an influence on the current trend. While there is inherent uncertainty with any prediction of future values, the five-year trend already includes two years of FFS risk scores (2019 and 2020) that do not exhibit the same increase observed from 2021 to 2023, which provides a smoothing effect in the event the FFS risk score increase slows down in the future.

In response to commenters concerned about incorporating previously excluded FFS data years 2021 and/or 2022, including previously excluded FFS data years does not contradict our position in prior year Advance Notice and Rate Announcements where CMS used the linear slope method to calculate the Part C normalization factors. Excluding those FFS data years under the historical methodology was necessary to allow CMS to avoid unreasonable projections during a period of unpredictability. CMS' five-year linear slope methodology, that has largely been used since 2007, to calculate model normalization factors assumes that risk scores will change uniformly from one year to the next and is sensitive to extreme events. Given this, a single anomalous data point can have a large impact on projected FFS risk scores possibly yielding an unreasonable normalization factor, particularly where that data point is the first and/or last value used for projecting the trend. Including anomalous data in the trend, such as 2021 and 2022 FFS risk scores, under the historical linear slope methodology can have a large impact on the projected value, the directionality of which is dependent on where the anomalous data point is in the slope. In contrast, a multiple linear regression methodology can account for the anomalous COVID-19 data point and calculates slopes independent from the decrease in risk score level between the two time periods. It achieves this by not treating all data years uniformly when it comes to their impact on the trend calculations and projection, negating the need to exclude data years as is required under the linear slope methodology.

Comment: Some commenters believe that the rationale for using the linear regression methodology as proposed, specifically incorporating the most recent five years of data, is inconsistent with the rationale for the RxHCC methodology and what CMS has said in prior Rate Announcements whereby CMS excluded periods substantially impacted by the COVID-19 pandemic because they were atypical. The commenters urged CMS to take a consistent approach toward Part C and Part D normalization by reconsidering the data years used in the Part C normalization factor methodology.

Response: There are two important considerations driving the different approaches to calculating the normalization factors for the Part C (MA and PACE) and Part D risk adjustment models.

First, the historical average Part D risk scores used to calculate the Part D normalization factors for MA-PD plans and PDPs include the most recent years available (2018-2022), which are lagged one year compared to the historical average FFS risk scores used to calculate the Part C normalization factors for MA and PACE (2019-2023). In response to commenters concerned with inconsistency between the CMS-HCC model and RxHCC model, CMS notes that Part D normalization factors include risk scores of enrollees in both MA-PD plans and PDPs, while only risk scores of beneficiaries in FFS are used to calculate the Part C normalization factors. Due to additional time needed for complete encounter data submissions from MA organizations, the availability of risk scores used to calculate RxHCC model normalization factors are lagged one year relative to CMS-HCC risk scores, meaning that the most recent final reconciled RxHCC risk score is for 2022 (using diagnoses from 2021 dates of service) and, therefore, the 2023 RxHCC risk score is not available for consideration in the calculation of the RxHCC normalization factor for CY 2025. Because we do not have a 2023 risk score for the RxHCC normalization factor calculation to evaluate the accuracy of the multiple linear regression approach, we do not believe it is prudent at this time to alter the methodology for the RxHCC model normalization factors. For the RxHCC model normalization factors (see Attachment IV, Section H), we are being consistent with the method finalized in CY 2024 for the CMS-HCC models when 2022 was the most recent risk score available.

Second, the use of the multiple linear regression equation avoids the need to exclude prior years of risk score data because it takes into account the different slopes that exist before and after the onset of the COVID-19 pandemic, effectively capturing the impact of the pandemic in our projections. As explained in the prior responses to public comments in this section and in the CY 2025 Advance Notice, the linear slope approach – the approach for which CMS determined that excluding certain past years of data was necessary – is vulnerable to significant changes in the trend, as was observed during the COVID-19 pandemic when risk scores dropped significantly due to atypically low utilization. The Part D normalization factors for CY 2025 are calculated using the linear slope approach in part because we do not believe there is sufficient post-COVID-19 risk score experience to conclude that the multiple linear regression approach is necessary to calculate a reasonable projection of average 2025 risk scores. As also stated in the CY 2025 Advance Notice, for future years, when more post-COVID-19 risk scores are available for RxHCC models, CMS will evaluate the multiple linear regression approach, but we believe that using that approach for the RxHCC models is not prudent for CY 2025.

Comment: Many commenters supported or were open to changing the normalization factor methodology, including the use of the multiple linear regression methodology. Of these commenters, most stated support for alternative implementations of the multiple linear regression

methodology that use alternative regression inputs for FFS data years and/or the COVID-19 indicators.

Many commenters believed that there were more appropriate ways to use the COVID-19 indicator, rather than the binary ("0" or "1") flag that CMS used in their multiple linear regression to indicate a pre- and post-COVID-19 period, given that the impact of COVID-19 is not consistent across each year and assuming as such may not result in a good prediction of 2025 average FFS risk scores. A number of these commenters suggested CMS re-evaluate the COVID-19 indicator used for years after 2022.

Some of these commenters suggested CMS instead use a COVID-19 indicator that is variable and reflects the impact COVID-19 had on each year's risk scores rather than a categorical binary variable. The commenters recommended a quantifiable indicator that assumes the post-COVID-19 growth in risk scores seen since 2021 will phase out over time such that the post-COVID-19 trend will ultimately resemble the pre-COVID-19 trend. Multiple other commenters suggested an alternative methodology whereby the COVID-19 indicator decays over time at a constant rate.

A few commenters believe that CMS should indicate 2023 as a non-COVID-19 year, indicated by a "0", with one commenter stating this is appropriate given the official end of the federal public health emergency was in 2023.

A couple of commenters also recommended adopting a non-linear "Decay" adjustment to account for the unique post-COVID-19 FFS risk score pattern in the trend when projecting the future risk score average to set the normalization factor. The Decay adjustment assumes that the initial post-COVID-19 growth from 2021 to 2022 that is higher than growth from 2022 to 2023 will continue into years beyond 2024. This modeling approach assumes that there was an initial impact of COVID-19 on FFS risk scores that declines over time, and that FFS risk score growth will eventually return to the trend seen pre-COVID-19, while still incorporating a post-COVID-19 "shift." Commenters stated that the Decay approach allows the proposed methodology to retain the anomalous 2021 data point while using a non-linear rather than linear assumption, which they believe will mitigate the bias that a linear model would have.

Some of the recommended alternative approaches to the proposed multiple linear regression methodology by the commenters include:

- Using FFS data from 2017 – 2023 or 2018 – 2023;
- Using FFS data from 2017 – 2023, but excluding 2021 and/or 2022 FFS data;
- Modifying the COVID-19 indicator to reflect a gradually declining factor that more closely reflects the pre-COVID-19 trend;
- A COVID-19 indicator that decays over time at a constant rate;

- Inputting “0” for the COVID-19 indicator for years after 2021;
- Inputting “0” for the COVID-19 indicator for 2023; and/or
- Inputting “0” for the COVID-19 indicator for 2025.

Response: CMS thanks the commenters for the thoughtful feedback and the valuable analyses. We also appreciate the support in using a new multiple linear regression methodology for use in calculating the 2025 Part C normalization factors. CMS is finalizing the proposed normalization factors that were developed using the multiple linear regression methodology that accounts for the different trends in the FFS risk scores between the pre-COVID-19 period and the period during and after by including a binary COVID-19 indicator for time periods before and after the onset of the COVID-19 pandemic in the regression.

This COVID-19 indicator accounts for the distinct difference in the level and year-over-year change in the average FFS risk score between the pre- and post-COVID-19 periods in a way that does not necessitate the need to exclude any years of data. The COVID-19 indicator itself is a categorical and binary variable that identifies in the regression whether an average FFS risk score is based on dates of service before or after the onset of the COVID-19 pandemic.

Many commenters based their recommendations for adjusting the COVID-19 indicator on the assumption that the post-COVID-19 trend will recover completely and return to pre-COVID-19 levels resulting in a COVID-19 indicator that will decrease and eventually phase out over time. At this time, CMS believes there is insufficient post-COVID-19 FFS risk score data to adequately analyze whether it is appropriate to make this assumption and to change the COVID-19 indicator from a categorical variable, indicating pre- and post-COVID-19 periods, to a variable indicator that is adjusted based on a prediction of future trend with confidence. CMS also believes the use of a categorical variable provides valuable transparency in that it is a clear and replicable approach for accounting for the impact of the COVID-19 pandemic in the regression and relies on basic information without the need to make inferences about the impact of certain years in the historical data on future trends.

While CMS will be finalizing the normalization factors for MA and PACE developed using the multiple linear regression methodology as proposed in the CY 2025 Advance Notice, we will continue to assess trends and the appropriateness of alternate methods for future years.

Comment: A few commenters stated that the multiple linear regression Part C normalization factor methodology predicts a higher rate of growth in FFS risk scores in the years following the COVID-19 pandemic than in the years prior to the pandemic and does not account for the observed deceleration in risk score growth from 2022 to 2023. Multiple commenters recommended CMS continue to use the historical linear slope methodology to calculate the 2025 Part C normalization factors. Most of these commenters believe that using the historical

linear slope methodology produces a normalization factor that more closely aligns with the pre-COVID-19 trend, which they believe is more appropriate.

Multiple commenters provided their own Part C CMS-HCC normalization analysis using the linear slope methodology under different scenarios, including using more historical FFS data in the trend (2017-2019) and/or continuing to exclude years affected by COVID-19 (2021 and/or 2022). Specifically:

- A couple of commenters recommended using a five-year average but excluding 2020 and 2021 FFS risk scores from the trend (using years 2017-2019, 2022-2023);
- Several commenters recommended excluding only 2021 FFS risk scores;
- Multiple commenters recommended excluding only 2021 and 2022 FFS risk scores;
- A number of commenters recommended excluding only 2021 FFS risk scores, but also including 2017 and 2018 as additional years used in the trend;
- A few commenters recommended using 2017-2023 FFS risk scores but excluding 2021-2022 FFS risk scores; and
- Another commenter recommended CMS follow prior years methodology and exclude 2021 FFS risk scores but keep 2018 FFS risk scores in order to have a consistent 5 years of data points.

Response: For CY 2024, to ensure a reasonable projection of FFS risk scores given the information available at the time, CMS appropriately excluded FFS risk scores that had an anomalous effect on our trend under the historical linear slope methodology. As noted in the CY 2025 Advance Notice, our analysis showed that when the CY 2025 normalization factor for the Part C risk adjustment models are calculated with a linear slope using the most recent average FFS risk scores (2019 through 2023, excluding 2021), the resulting normalization factors are the same (2024 CMS-HCC model) or lower (2020 CMS-HCC model) than the CY 2024 normalization factor, predicting that average FFS risk scores would not grow between CY 2024 and CY 2025, or would decrease. Similarly, when performing the same calculation but also excluding the 2022 average FFS risk score, CMS observes that the 2025 normalization factor for the 2020 CMS-HCC model again comes in lower than the 2024 normalization factor. We do not believe that excluding fewer years of risk scores, as suggested by several commenters, improves the projections that result from using the linear slope approach. Because the linear slope methodology produces factors that CMS does not consider reasonable projections for CY 2025, CMS developed and is finalizing normalization factors using a more sophisticated multiple linear regression methodology for calculating normalization factors for CMS-HCC models for CY 2025.

Excluding data years is not necessary when using the multiple linear regression methodology due to how the multiple linear regression approach does not assume uniform variability across all

years and provides a way to take into account the variability in FFS risk scores due to the pandemic. Previously, using the linear slope methodology, our projections treated each year uniformly without explicitly considering the varying impact of the COVID-19 pandemic.

Regarding commenters who supported including additional years of historical FFS risk scores, as stated in an earlier response, CMS believes including historical 2017 and/or 2018 FFS risk scores would place emphasis on data that is not influencing the current trend. While there is inherent uncertainty with any prediction of future values, the five-year trend already includes two years that do not exhibit the same increase observed from 2021 to 2023, which provides a smoothing effect in the event the FFS risk score increase slows down in the future.

Comment: Some commenters recommended that CMS provide more transparency through releasing additional data and conducting further analysis to test the accuracy of the predictions calculated under the multiple linear regression normalization factor calculation methodology. A few commenters suggested that CMS delay implementation of the new methodology for developing normalization factors until more analysis is conducted and made public.

Response: We appreciate the request for transparency. We will continue to consider additional ways in which we can engage with stakeholders as we consider changes to the normalization factor methodology for future years and appreciate commenter input.

Comment: Several commenters are concerned the proposed normalization factors will have a negative impact on ESRD payment and recommended CMS use the same considerations provided by the commenters in relation to the proposed non-ESRD CMS-HCC normalization factor methodology. A commenter specifically recommended CMS continue to use the historical linear slope methodology and continuing to exclude the 2021 FFS risk score.

Response: CMS appreciates the feedback and concerns of the commenters related to ESRD payment. As discussed in prior year Advance Notices and in this document, the normalization factor is intended to maintain an average FFS risk score of 1.0 in each payment year, as well as provide payment stability between model calibrations. When calculating the normalization factor for the ESRD CMS-HCC risk adjustment models, CMS carefully considered the approaches for projecting a reasonable prediction of future FFS risk scores under these models. While we considered impacts on all normalization factor calculations, including those for the ESRD models, CMS believes the finalized normalization factors are appropriate and produce reasonable estimates of what the average FFS risk scores will be under the ESRD models in 2025.

Comment: Several commenters provided suggestions for how CMS may calculate the normalization factors that are unrelated to the methodologies discussed in the CY 2025 Advance Notice. These included individual commenters who recommended:

- using beneficiary level risk score data to calculate normalization factors;
- using MA risk scores to calculate the normalization factors rather than FFS risk scores; and
- applying a limit to the normalization factor applied to I-SNP beneficiaries.

Response: CMS thanks the commenters for their recommendations. The CMS-HCC models are calibrated using diagnostic and cost information for beneficiaries enrolled in Medicare FFS and the average FFS risk score is a 1.0 in the year used to set the model relative factors (i.e., the denominator year), which aligns with the ratebook that is also standardized to a 1.0 FFS risk score. For years other than the denominator year, the average risk score can vary from 1.0 due to an underlying trend that reflects changes in the health status and demographic characteristics of the population, as well as changes in coding practices. The normalization factor is a technical adjustment that must be made to risk scores produced by a risk adjustment model to account for the underlying trend so as to maintain an average FFS risk score of 1.0 and to do so, the normalization factor should be a reasonably accurate prediction of the average FFS risk score in the payment year. For these reasons, we do not believe that using MA risk scores to calculate the normalization factor is appropriate. While we appreciate the suggestions to change how we calculate the normalization factors, we believe that the proposed normalization factors – using a multiple linear regression approach with the five most recent years of average FFS risk scores available – will produce a reasonable estimate of the average FFS risk score under each model in 2025.

**Section O. Sources of Diagnoses for Risk Score Calculation for CY 2025**

***Non-PACE Organizations***

CMS did not receive comments regarding the proposal for the sources of diagnoses for Non-PACE organizations for CY 2025. CMS will continue the policy adopted in the CY 2024 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.

***PACE Organizations***

Comment: CMS received a few comments addressing the sources of diagnoses for PACE and PACE Data Transition. Those comments were supportive of CMS' policy proposal to continue the same method of pooling risk adjustment-eligible diagnoses from the following sources to calculate a single risk score for CY 2025: (1) encounter data, (2) RAPS, and (3) FFS (fee for service) claims.

Response: CMS appreciates the support for the proposal and will continue using the same method of calculating risk scores under all risk adjustment models that we have been using 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) RAPS data, and (3) FFS claims.

Comment: Comments also supported CMS' decision to begin transitioning PACE organizations from the RAPS to the encounter data system (EDS), stating that they would appreciate guidance and technical support in doing so. The comments suggested the need for guidance to PACE organizations for properly capturing the data elements to submit to EDS, especially for participant assessments conducted in the PACE centers, and around telehealth, behavioral health, physical therapy, occupational therapy, and social work. In addition, a commenter asked whether the transition from RAPS to EDS for diagnosis submission for primary care was limited to diagnoses that would have been captured in RAPS. Commenters also requested clarity on a list of items, such as: the timing between the transition from EDS to an updated model, whether the intention is for CMS to move PACE organizations directly to the 2024 CMS-HCC model or to the 2020 CMS-HCC model first or adopt a blended approach like some existing CMS Innovation Center models.

Response: CMS thanks the commenters for supporting the start of transitioning PACE organizations from RAPS to EDS. While we have not specified a timeline for full transition to EDS submissions, CMS is hopeful that all PACE organizations can submit all risk adjustment eligible diagnoses for 2025 dates of service consistent with the instructions released by CMS on January 29, 2024.[19] We encourage PACE organizations to begin submitting EDRs or at a minimum CRRs for services that do not generate a claim to the EDS as soon as possible. For technical instructions to PACE organizations on the submission of risk adjustment data to the EDS for services for which a claim is not generated, please refer to the HPMS memo CMS released on January 29, 2024.[20] PACE organizations should note that there is no change in existing risk adjustment rules (e.g., acceptable sources of data - hospital inpatient, outpatient, and professional); the change is in the method used to determine which diagnoses are eligible for risk adjustment from RAPS to encounter data, referred to as encounter data filtering. PACE organizations should refer to the 2015 HPMS memo regarding encounter data filtering logic for information about encounter data filtering for professional services.[21] We note, the filtering of risk adjustment eligible diagnoses from professional encounter data uses Current Procedural Terminology (CPT)/Healthcare Common Procedure Coding System (HCPCS), and provider

[19] Refer to the January 29, 2024 HPMS memo titled "PACE Organization Risk Adjustment Submissions to the Encounter Data System."
[20] Refer to the January 29, 2024 HPMS memo titled "PACE Organization Risk Adjustment Submissions to the Encounter Data System."
[21] Refer to December 22, 2015 HPMS Memo titled "Final Encounter Data Diagnosis Filtering Logic memo."

specialty (e.g., occupational therapist) is not a component of filtering in encounter data. CMS is committed to working closely with PACE organizations to support the transition from the RAPS to the EDS and will continue to provide technical assistance and guidance to support the successful submission of the necessary data. CMS will take the comments and questions posed into consideration as we consider future communications.

**Attachment IV. Responses to Public Comments on Part D Payment Policy**

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

Comment: Commenters expressed support for CMS' implementation of the IRA-related changes to the Part D benefit. Several commenters expressed support for the elimination of the coverage gap phase of the benefit and the establishment of a $2,000 annual OOP threshold for CY 2025. A commenter also expressed support for the inclusion of language reminding plans that Advisory Committee on Immunization Practices (ACIP)-recommended adult vaccines are exempt from beneficiary cost sharing.

Response: CMS appreciates the commenters' support.

Comment: Some commenters expressed concern about the impact of the IRA-related changes to the Part D benefit. A commenter requested that CMS acknowledge that some elements of the IRA risk creating a series of consequences that could jeopardize access to Part D drugs and further requested specific relief granted by CMS through existing statutory flexibility or the use of waiver authority.

Response: CMS understands that the Part D redesign may lead to changes in the Part D market. We believe that the redesign will improve drug affordability and reduce OOP costs for Part D beneficiaries. CMS is committed to engaging with interested parties to ensure a successful implementation of the redesign.

Comment: A commenter expressed concern that lower beneficiary cost sensitivity due to the IRA-related changes to the Part D benefit could create significant induced utilization and requested that CMS expand the induced utilization factor to its prescription drug per capita estimates for CY 2025 and adjust the API for CY 2025.

Response: The API calculation is defined in section 1860D-2(b)(6) of the Act and specifies that we use the 12-month period ending in July of the previous year. For the CY 2025 Part D benefit parameters, this is the period from August 2023 through July 2024. While the benefit changes of the IRA for CY 2025 may have effects on overall utilization, it is not appropriate to consider them in the API for CY 2025 given that the statutorily defined period does not include CY 2025. As the IRA impacts are observed in the PDE experience and projected for the periods in future contract years, we will consider how to account for these possible utilization changes.

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

No in-scope comments received.

**Section C. Part D Premium Stabilization**

Comment: A commenter expressed support of the premium stabilization provisions of the IRA but noted that there is potential for significant beneficiary impacts in plans that incur larger than average premium increases due to the Part D redesign and encouraged CMS to seek additional mechanisms to assist Part D sponsors in successfully implementing the redesign.

Response: CMS appreciates the support for the premium stabilization provision. CMS is committed to engaging with interested parties to ensure successful implementation of the Part D redesign. CMS acknowledges that premium stabilization functions to phase in the effects of the IRA on the average basic Part D premium, but that Part D plans may have premium changes different from the average, particularly in CY 2025 with the implementation of section 11201 of the IRA. However, the statute does not provide CMS with a mechanism to reduce the variation in basic Part D premiums around the average across Part D plans.

Comment: A commenter requested that CMS modify the rebate reallocation process to allow for greater flexibility in rebate changes in response to the redesigned Part D benefit.

Response: CMS notes that the rebate reallocation process is outside the scope of this document.

**Section D. Part D Calendar Year EGWP Prospective Reinsurance Amount**

Comment: A commenter expressed support for the updated methodology for Part D Calendar Year EGWP prospective reinsurance payment amounts.

Response: CMS thanks the commenter for their support.

Comment: A commenter expressed opposition to a CY 2025 change in methodology for Part D Calendar Year EGWP prospective reinsurance payment amounts.

Response: CMS thanks the commenter for their input, and we refer commenters to the Final CY 2025 Part D Redesign Program Instructions[22] for additional discussion of the Part D Calendar Year EGWP prospective reinsurance amount.

[22] Refer to CMS' Final CY 2025 Part D Redesign Program Instructions.

**Section E. Part D Risk Sharing**

Comment: Many commenters suggested that CMS explore alternative solutions to narrow risk corridors for 2025 and later years, given the significant changes to the Part D program that will take effect in 2025. Commenters expressed concern that maintaining the existing risk corridor thresholds could increase uncertainty and instability in the Part D market and result in upward pressure on Part D premiums. Most of these commenters recommended that CMS use its demonstration authority under section 402 of the Act to narrow the risk corridors, stating that CMS previously proposed a comparable demonstration in 2019 for CY 2020 regarding a proposed rule modifying safe harbor protection under the Anti-Kickback Statute. In addition, a commenter noted that on multiple occasions, MedPAC suggested risk corridor adjustments to temporarily provide plan sponsors with greater protection during a transition to a new benefit structure.

Response: We appreciate the concerns raised by the commenters. As noted in the CY 2025 Advance Notice, under section 1860D-15(e)(3)(C) of the Act and § 423.336(a)(2)(ii), CMS may establish a risk corridor with higher threshold risk percentages for Part D risk sharing. However, the statute does not permit CMS to narrow the corridors relative to the CY 2011 thresholds. While CMS acknowledges commenters' suggestions to use demonstration authority under section 402 of the Act to narrow the risk corridors, we note that doing so is outside of the authority of this document. Moreover, CMS does not believe that narrowing risk corridors would reduce or stabilize premiums any more than will already be accomplished by the premium stabilization provision in the IRA.

Comment: A few commenters expressed support for not widening the risk corridors.

Response: CMS thanks the commenters for their support.

Comment: A commenter requested that CMS widen the risk corridors for CY 2025 to "minimize the risk to plans."

Response: Widening the risk corridor would increase the risk associated with providing the Part D benefit and reduce the risk sharing amounts provided (or recouped) by CMS. CMS does not believe it is appropriate to widen the risk corridors at this time but will continue to evaluate the risk sharing amounts each year to determine if wider corridors should be applied for Part D risk sharing in the future.

**Section F. Retiree Drug Subsidy Amounts**

No comments received.

**Section G. RxHCC Risk Adjustment Model**

Comment: Of the commenters who remarked specifically on the proposal to update the RxHCC model to reflect the IRA Part D redesign, nearly all supported the update. One commenter expressed concerns that the update could result in financial volatility and recommended that CMS phase in the model update over a four-year period.

Response: CMS thanks the commenters for supporting the proposed update. As stated in the CY 2025 Advance Notice, the IRA made substantial changes to the Part D benefit for CY 2025, which is expected to result in increased gross plan liability, and changes in relative costs across beneficiaries and plans. We believe that a phase-in to the proposed updated RxHCC risk adjustment model would not be appropriate because the payments to Part D sponsors in CY 2025 would less accurately reflect the expected changes in relative plan costs under the redesigned benefit. For this reason, CMS is finalizing the policy to update the RxHCC model to reflect the IRA Part D redesign without a phase-in.

Comment: A few commenters expressed concerns that while the proposed RxHCC model update is expected to increase risk scores for some populations, such as low-income beneficiaries in SNPs, the increases would still be insufficient to account for the projected increase in plan liability under the redesigned benefit. One of these commenters stated that risk scores for low-income beneficiaries would not increase as much as their expected liability, which would result in higher bids and require Part D plans serving high proportions of low-income beneficiaries to use additional rebate dollars to buy down basic Part D premiums to or below the low-income premium subsidy amount.

Response: We thank the commenters for their questions. While plan liability is increasing across all groups of beneficiaries, the average Part D risk score remains at 1.0 across the entire Part D market. Since the goal of risk adjustment is to ensure that payments to plans for beneficiaries who are expected to cost relatively more than average are higher than for beneficiaries who are expected to cost less than average, the role of the risk score is to adjust the plan bid in payment to ensure that the relative payments reflect these differences. Therefore, the 1.0 risk score is set for the average beneficiary, meaning that this average can increase over time if the average cost for a beneficiary is expected to increase. Because the average risk score must remain 1.0, even if plan liability is expected to increase, risk scores change in order to reflect how plan liability changes relative to the new overall average. Under the updated Part D model, risk scores for low-income beneficiaries tend to increase while those for non-low-income beneficiaries tend to decrease. For more information, please refer to slides from our September 2023 user group call, where we discussed the IRA Part D redesign updates to the RxHCC model. In these slides, we noted that plan liability is expected to increase overall under the redesigned benefit, but low-

income beneficiaries are expected to see a larger increase than the overall average, resulting in increased risk scores.[23]

Comment: Several commenters expressed further concerns about the proposed model's impact on low-income beneficiaries, including those enrolled in SNPs. A few of these commenters further said that because low-income beneficiaries generally have zero or minimal cost sharing, and many use protected class drugs, plans with high proportions of low-income or dually eligible beneficiaries have few methods for steering beneficiaries toward cost-efficient drugs. Some of these commenters asked CMS for additional details about how CMS accounted for SNPs in the model, with one commenter requesting CMS to phase in the model if SNPs were not appropriately accounted for in the model calibration.

Response: CMS recognizes the commenters' concern about the effect of the model update and the IRA Part D redesign on low-income beneficiaries, particularly those in SNPs. The diagnoses and costs of all low-income beneficiaries, including those enrolled in SNPs, are included in the RxHCC model calibration and accounted for with separate low-income segments, so any unique patterns of costs and utilization due to zero or minimal cost sharing among this group of beneficiaries will be reflected in the model relative factors. This is the same process that has been used in calibrating the model in previous iterations as well. Further, we published predictive ratios in the CY 2025 Advance Notice showing that the model tends to predict well for low-income beneficiaries across all deciles of risk, including in the highest deciles of predicted risk.

Comment: Several commenters expressed concerns about the model's impact on beneficiaries taking high-cost drugs, including specialty drugs. These commenters believed that by estimating the aggregate average cost, the model will tend to underpredict for beneficiaries who take high-cost drugs, as well as have a negative impact on populations with high variability in drug costs depending on potential treatment options. These commenters further said that this could result in plans adjusting benefits and formularies or increasing premiums to account for beneficiaries taking high-cost drugs. One commenter specifically noted that EGWP plan designs are negotiated directly with groups and have less flexibility to mitigate costs, which could result in higher premiums. Two commenters recommended that CMS incorporate a high-cost threshold into the model to account for outlier expenditures.

Response: We note that risk adjustment models, including both the CMS-HCC and RxHCC models, are intended to predict expected relative expenditures across key subgroups of beneficiaries. As measured by our predictive ratios, the RxHCC model does well at predicting across levels of risk, meaning beneficiaries broken out into groups based on their predicted drug costs. The models are not intended to predict the costs of individual beneficiaries, nor are they

[23] Refer to CMS' 2025 Part D Risk Adjustment Model Update User Group Call materials.

intended to have any influence on drug prescribing and uptake. Overall expected costs for a plan's expected enrolled population are reflected in the bid, and the risk adjustment model is intended to ensure that the payments to the plan adequately reflect its expected relative cost, compared to the national average.

Comment: A few commenters expressed concerns about the changes to relative factors for specific RxHCCs under the updated model. One commenter remarked that relative risk factors for some conditions, such as diabetes and rheumatoid arthritis, saw decreases or small increases for non-low-income enrollees over age 65 under the Part D model update. This commenter said that these conditions affect a significant portion of Medicare beneficiaries and recommended that CMS adjust the relative factors for these diseases and others for which the current RxHCC model underpredicts costs. One commenter expressed concern about the reduction in relative factors for Alzheimer's Disease (RxHCC 111) and Dementia, except Alzheimer's Disease (RxHCC 112), as a result of the Part D model update. This commenter believed that the reduced relative factors could result in the undervaluing of these conditions among Part D plans, incentivizing plans to develop more narrow formularies or implement more utilization management. The commenter asked CMS to clarify the reasons for these reductions.

Response: CMS appreciates the commenters' concerns. We note in the CY 2025 Advance Notice that when the RxHCC model is recalibrated to reflect an updated Part D benefit design, it can result in changes in relative factors of condition categories if the marginal cost attributable to an RxHCC changes differently than the average beneficiary cost. Given the impact of these relative changes, even if both non-low-income and low-income beneficiaries are expected to see increased plan liability, for RxHCCs where the increase for non-low-income beneficiaries is expected to be less than the corresponding increase for low-income beneficiaries, relative factors for the non-low-income segments will decrease to reflect their *relatively* lower plan liability. This would also occur if the expected marginal plan liability for some RxHCCs would be expected to increase less than marginal plan liability for other RxHCCs (regardless of what segments they are in). The RxHCC risk adjustment model is intended to predict relative costs (plan liability) based on the IRA Part D redesign in order to pay plans adequately across subgroups of beneficiaries. As with other HCC-based risk adjustment models, it is calibrated in such a way as to not influence prescribing behavior, formulary structures, or beneficiary utilization. For further information, please see the slides from our September 2023 user group call on the updates to the Part D model.[24]

[24] Refer to CMS' 2025 Part D Risk Adjustment Model Update User Group Call materials.

Comment: One commenter asked CMS to confirm that RxHCCs for Alzheimer's Disease (RxHCC 111) and Dementia, except Alzheimer's Disease (RxHCC 112), were crosswalked to the most recent available ICD-10 codes in model calibration.

Response: The RxHCC model maps beneficiaries' diagnoses to RxHCCs for model calibration using the ICD-10 codes valid in the base year of the model calibration. For example, for a model calibration using 2021 diagnoses, it would use ICD-10 codes valid in FYs 2021 and 2022 to cover all diagnoses in CY 2021. For plan payment, beneficiaries' diagnoses are mapped to RxHCCs based on ICD-10 codes valid in the data collection year for payment. For example, for CY 2023 payment, based on CY 2022 diagnoses, beneficiaries' diagnoses would be mapped using diagnosis codes valid in FYs 2022 and 2023 to cover all diagnoses in CY 2022.

Comment: One commenter remarked that CMS removed oral-only ESRD drugs that will be covered under Part B in CY 2025 from the model prior to the publication of the CY 2025 ESRD PPS Final Rule. This commenter said that it was premature to incorporate this into the model prior to the publication of the final rule, and the commenter stated that the dialysis provider community has requested an implementation period for these drugs in CY 2025 such that they would continue to be provided until CY 2026. Should this implementation period go into effect, this commenter recommended CMS include expenditures for these drugs in the model calibration for CY 2025.

Response: CMS appreciates the commenter's remarks. We calibrate the model based on what the Part D standard benefit structure is expected to be in the future payment year. Given the substantial time needed to calibrate the model, this future benefit year structure reflects the current law at the time of model calibration. As a result, we removed these drugs from the model for CY 2025 as the current law states that these drugs will be paid under Part B beginning in CY 2025.[25]

Comment: One commenter suggested that CMS include an RxHCC for chronic kidney disease stage 3 into the payment model as is done in the CMS-HCC model. This commenter believed that including this RxHCC would encourage Part D plans to promote early chronic kidney disease intervention.

Response: CMS appreciates the comment. It is important to note that the RxHCC model specifically predicts plan costs for prescription drugs, not medical costs. As a result, the list of RxHCCs may not always match the list of HCCs if the conditions are not strong predictors of both drug and medical costs, respectively.

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[25] 42 CFR § 413.174(f)(6); see also American Taxpayer Relief Act of 2012, Pub. L. No. 112-240, § 632(b), 126 Stat. 2313, 2354 (2013); Protecting Access to Medicare Act of 2014, Pub. L. No. 113-93, § 217(a)(1), 128 Stat. 1040, 1061 (2014); Stephen Beck, Jr., ABLE Act of 2014, Pub. L. No. 113-295, div. B, § 204, 128 Stat. 4010, 4065 (2014).

Comment: A few commenters suggested that CMS examine other methods where the underlying data and structure of the RxHCC model could be modified, such as incorporating prescription drug claims into the model to supplement medical diagnoses and incorporating concurrent data markers for drug conditions. One additional commenter suggested that CMS use two years of prior diagnosis data in order to better account for coding differences between encounter data and FFS claims. These commenters believed that these changes would improve model accuracy and better account for beneficiaries with large variability in drug costs.

Response: CMS thanks the commenters for their suggestions but notes that these suggestions are outside the scope of the information presented in the CY 2025 Advance Notice.

Comment: A few commenters suggested that CMS examine alternative prices for estimating expenditures, such as net (post-rebate) plan liability, post-POS pharmacy price concessions, reductions in manufacturer list prices for certain drug categories, or anticipated negotiated drug prices for 2026 and beyond. These commenters believed that using gross plan liability tends to overpredict costs for drugs with high rebates or price concessions and underpredicts costs for drugs with lower rebates or price concessions, and using these alternative prices would better reflect plan liability.

Response: CMS thanks the commenters for their recommendations. We regularly consider how to improve the RxHCC model and will continue to examine alternative prices to the extent to which they are present in available data.

Comment: Several commenters suggested that CMS incorporate expected changes in beneficiary utilization from the IRA Part D redesign into the Part D model. These commenters said that the reduced annual OOP threshold, removal of cost-sharing in the catastrophic coverage phase of the benefit, capped copayments for insulin, and the Medicare Prescription Payment Plan's smoothing of OOP costs, could create an incentive for beneficiaries to take more expensive drugs, which would not be reflected in prior years' data.

Response: CMS appreciates the commenters' concerns. Because the model predicts the association between diagnoses and demographics and plan drug expenditures using historical data, we believe that modeling future behavior would result in error in the model and inaccurate predictions of relative cost. Due to this risk, we do not believe that it would be appropriate to model expected changes in behavior into the model and believe that continuing to calibrate on the most recent available data, and waiting to account for these changes in future iterations of the model, is the most prudent approach.

Comment: Of the commenters who commented specifically on the proposal to calibrate the CY 2025 model for Non-PACE organizations using 2021 diagnoses and 2022 expenditures, the majority were in support of using more recent data. These commenters believed that more recent

data would be more reflective of patterns expected in 2025. A smaller number of commenters supported the alternative model, calibrated using 2018 diagnoses and 2019 expenditures, citing concerns about using diagnosis data occurring during the COVID-19 pandemic.

Response: CMS appreciates' commenters feedback and support. While we understand the concern with using diagnosis data from during the COVID-19 pandemic, we noted in the CY 2025 Advance Notice that available analysis shows that drug spending was less affected by the pandemic than medical spending. As a result, we believe that value of more recent data having utilization and cost patterns closer to those in CY 2025 outweigh concerns about the potential impact of the pandemic on the model coefficients, so we are finalizing the policy to use the model calibrated on 2021 diagnoses and 2022 expenditures as proposed in the CY 2025 Advance Notice.

Comment: Two commenters supported the proposed clinical update of the model for PACE organizations to use ICD-10 codes and align with the model for Non-PACE organizations. These commenters asked CMS to provide additional information about the impact of this update on PACE plans.

Response: CMS thanks commenters for their support of the clinical update to the PACE model. We believe that this update was necessary in order to align the list of payment RxHCCs for PACE and Non-PACE organizations along with updating the PACE model to be calibrated on more recent years of data, which will be important for estimating relative costs for CY 2025 with more accuracy. As discussed in the CY 2023 Advance Notice, the clinical update for Non-PACE organizations was originally made to improve the model's ability to predict drug spending by accounting for more current drug utilization and spending trends and changing RxHCCs that no longer predicted costs well. Therefore, we also believe that this update is necessary to improve predictive power for PACE organizations. Additionally, CMS provided Part D sponsors with estimated payment year 2022 risk scores under the current and proposed RxHCC models to aid in evaluation of the model proposal.

Comment: One commenter expressed support for the proposed new constraint for age categories for both PACE and Non-PACE versions of the RxHCC model. This commenter also suggested that CMS consider widening existing age ranges or reducing the number of age categories in future versions of the model. Another commenter requested that CMS provide additional information about the impact of the constraints, including publishing unconstrained values of the coefficients.

Response: CMS appreciates these comments. As mentioned in the CY 2025 Advance Notice, this change was implemented because more age categories would have negative coefficients under the new model, posing the risk of having more beneficiaries with risk scores of zero if they did not have any payment RxHCCs. Regarding the impact of these age constraints, the

unconstrained coefficients in the older age categories in the aged (65+) model segments were initially negative coefficients or low positive coefficients, and the constraints permitted these age categories to have positive relative factors. CMS has typically applied constraints when a coefficient is negative, and the general effect is to average the coefficient across the factors that are being constrained.

Comment: Some commenters asked that CMS allow for a 60-day comment period for the RxHCC model so that plans have more time to evaluate the methodological changes. One additional commenter asked CMS to include analyses similar to the ones provided in the September 2023 user group call into future iterations of the Advance Notice.

Response: CMS thanks the commenters for these suggestions and will take these into consideration. We acknowledge the commenters' request for more time to review the policy proposals. Per section 1853(b)(2) of the Act, the Advance Notice of proposed changes to the methodology and assumptions used to determine annual MA capitation rates and the risk and other factors used in adjusting MA capitation rates under section 1853(a)(1)(C) is required to have a minimum 30-day comment period. Section 1860D-15(c)(1)(D) of the Act requires that CMS publish the risk adjustment factors for Part D at the time of publication of risk adjustment factors for Part C, which we propose in the Advance Notice and finalize in the Rate Announcement for the applicable year, per 423.329(b)(4). The CY 2025 Advance Notice was released on January 31st, 2024, and comments were accepted through 6 PM Eastern Time on Friday March 1, 2024 (30 days).

CMS believes that the period provided for comments on the CY 2025 Advance Notice is sufficient. In setting these timelines, we seek to achieve multiple goals, including providing the statutory-required amount of time for public comment while also releasing the Advance Notice using more current data to calculate the risk and other factors used to adjust MA capitation rates and ensuring that the Rate Announcement is published by the statutory deadline.

**Section H. Normalization for the RxHCC Risk Adjustment Models**

Comment: Several commenters supported the continued use of the linear slope methodology to calculate Part D (RxHCC) normalization factors, while other commenters were neutral as to the methodology used for calculation. A few commenters supported the continued exclusion of risk scores that were impacted by the COVID-19 pandemic.

Response: CMS appreciates the support and is finalizing the separate MA-PD and PDP RxHCC normalization factors as proposed in the CY 2025 Advance Notice, which is to use CMS' historical five-year linear slope methodology and average risk scores from 2018-2022, excluding 2021, for Non-PACE organizations and average risk scores from 2016-2020 for PACE organizations.

Comment: Some commenters supported the proposal to use two separate normalization factors for MA-PD plans and PDPs, pointing out that there has been an increasing divide between MA-PD plans and PDPs with regard to their premiums and enrollment. Commenters in support of the proposal mentioned several reasons that MA-PD plans are at an advantage, such as MA-PD plans' ability to use MA rebates to buy down Part D premiums. One commenter stated that MA organizations may have higher coding intensity than FFS and may have favorable selection of healthier enrollees. These commenters agreed with CMS' analysis of diverging costs and risk scores between the two sectors and stated that without the new intervention, disparities would continue and present increased costs and premiums for PDPs relative to MA-PD plans, threatening the solvency of PDPs and the accessibility of options for beneficiaries. A couple of commenters believed that this proposal was a good first step, but that CMS should do more to stabilize the PDP market.

A commenter stated that CMS should continue to monitor the trends in Part D risk scores to ensure that PDPs remain a viable offering in the Part D market and that systematic differences between the two sectors do not result in a financial disadvantage to PDPs that undermines the Part D program's market-based structure built on competition among private plans.

Response: CMS appreciates the support and is finalizing the separate normalization factors for MA-PD plans and PDPs that reflect the risk score trend in each sector of the Part D market for the RxHCC risk adjustment models as proposed. We will continue to monitor MA-PD and PDP risk score trends.

By using separate normalization factors for MA-PD plans and PDPs, risk scores will more accurately reflect Part D costs in each of these two sectors of the Part D market that are driven by a variety of market-based variables, including the overall benefits that they are able to manage, the lack of an ability of PDPs to affect the submission of diagnoses in FFS, and available strategies used to manage Part D costs. CMS believes that the proposed policy will best address growing disparities between MA-PD plans and PDPs in order to ensure a level playing field, allowing for more fair competition between MA-PD plans and PDPs so that beneficiary options for Part D coverage are sustained.

Comment: Several commenters suggested that disparity in underlying demographics was the cause of the increasingly divergent risk scores observed between MA-PD plans and PDPs. Commenters mentioned that there has been increasing enrollment in SNPs (including D-SNPs) and decreasing enrollment of low-income beneficiaries in PDPs in recent years, which has the effect of increasing overall risk scores for MA-PD plans and decreasing overall risk scores for PDPs, regardless of any differences in coding practices. Commenters asked whether CMS considered changes in underlying demographic trends and care delivery differences when developing the proposed methodology. Several commenters were concerned that the proposal for

separate normalization factors for MA-PD plans and PDPs did not properly account for changes in demographics to both groups, particularly regarding populations with higher Part D utilization and costs. Another commenter suggested that CMS should control for population changes by considering the trend in risk scores for members persisting in MA-PD plans and PDPs from year to year, rather than the total MA-PD and PDP populations without adjustment.

Response: CMS appreciates the feedback and concerns of the commenters about using separate normalization factors for MA-PD plans and PDPs. The IRA redesign of the Part D benefit in CY 2025 will result in significant changes in plan liability, giving greater importance to direct subsidy payments to cover costs for which plans are liable, and to the role of risk adjustment in payment. Given this significant change in the Part D benefit and a trend of growing divergence in risk scores between MA-PD plans and PDPs, we are finalizing the proposal to apply one normalization factor to MA-PD plans and another to PDPs for CY 2025.

The normalization factor is a technical adjustment applied to risk scores in the payment year to account for underlying trends that reflect changes, such as those in coding and population characteristics, between the denominator year and other years such that the average risk score is no longer 1.0. The normalization factor serves to maintain a 1.0 average risk score when a model is used to calculate risk scores for years other than the year used to relativize the model coefficients (i.e., the denominator year). In developing the proposed methodology, CMS carefully considered data related to underlying demographics and care delivery differences between MA-PD plans and PDPs when creating the proposed policy. We found that this increase in MA-PD plan enrollment combined with the different coding and cost patterns for enrollees in MA-PD plans and PDPs has resulted in a diverging trend in average MA-PD plan and PDP risk scores over time, resulting in differing ability of the risk scores to predict costs for MA-PD plans and PDPs. These differentials put upward pressure on standardized bids for PDPs and, as a result, create an unlevel playing field that generally inhibits fair competition between MA-PD plans and PDPs. By using separate normalization factors for MA-PD plans and PDPs, risk scores will more accurately reflect Part D costs in each of these two sectors of the Part D market that are driven by a variety of market-based variables, including the overall benefits that they are able to manage, the lack of an ability of PDPs to affect the submission of diagnoses in FFS, and available strategies used to manage Part D costs. CMS believes that the proposed policy will best address growing disparities between MA-PD plans and PDPs in order to ensure a level playing field, allowing for more fair competition between MA-PD plans and PDPs so that beneficiary options for Part D coverage are sustained.

Comment: Some commenters believed that because the proposed separate normalization factors do not distinguish between different types of MA-PD plans, certain plans would be disproportionately negatively impacted including D-SNPs, I-SNPs, locally-based, not-for-profit plans, and any plan that disproportionately serves a high-cost group of enrollees, such as those

with serious chronic conditions, dually eligible individuals, and low-income beneficiaries. A commenter stated their belief that, in addition to serving a higher-cost population, these plans may work on smaller margins and have limited resources to devote to enhancing coding practices for the optimization of risk adjustment outcomes. Therefore, the normalization method applied to all MA-PD plans might not be accurate for these smaller groups and cause further cost pressures for them. Another commenter pointed out that D-SNPs may have to use higher MA rebates to buy down Part D premiums compared to non-D-SNPs; this could have the effect of making D-SNPs less attractive than other MA-PD plan options in the market.

Several commenters suggested that CMS should exclude SNPs from the normalization factor calculation, with multiple commenters recommending that including beneficiaries in SNPs in the normalization factor, but not the National Average Monthly Bid Amount (NAMBA), may create premium distortions because beneficiaries enrolled in SNPs have substantially higher risk scores than their non-SNP counterparts.

A couple of commenters requested that CMS provide additional information on how the proposed separation of the Part D model normalization factors into MA-PD and PDP impacts traditionally high costs populations, such as those dually eligible for Medicare and Medicaid and low-income subsidy (LIS) versus non-LIS members, and plans that serve higher-cost beneficiaries, such as D-SNPs, HIDE-SNPs, and FIDE-SNPs.

Response: CMS appreciates the comments. By using separate normalization factors for MA-PD plans and PDPs, risk scores will more accurately reflect Part D costs in each of these two sectors of the Part D market that are driven by a variety of market-based variables, including the overall benefits that they are able to manage, the lack of an ability of PDPs to affect the submission of diagnoses in FFS, and available strategies used to manage Part D costs. We appreciate the concerns expressed and note that, as in Part C, normalization is intended to set the average risk score at 1.0, and our unique use of separate MA-PD and PDP normalization factors is because, although the statute treats the Part D as one market, these two segments of the market operate quite differently. We do not anticipate that having two separate normalization factors will alter the general direction that bids and premiums move in each sector as a result of the new Part D benefit, and we expect that incentives to compete will continue to play a strong role. We also want to recognize that the low-income premium subsidy protects low-income beneficiaries from paying basic Part D plan premiums. Finally, we do not think it is appropriate to exclude any populations from the calculation of the normalization factors, since the 1.0 is necessarily across the entire market, regardless of their role in setting the NAMBA.

Comment: Some commenters stated their belief that the proposed update to the Part D normalization factors is unbalanced, with the negative impact being concentrated among MA-PD plans, with one commenter stating that this disadvantages MA organizations that offer only MA-

PD plans. Some commenters believed that the proposed policy forces MA-PD plans and their beneficiaries to absorb costs that would have otherwise been incurred in the standalone PDP market and it would raise bids (and premiums) for MA-PDs relative to PDPs. Commenters believe a drop in MA-PD revenue could potentially impact beneficiary access to supplemental benefits, reduce benefit generosity, increase cost-sharing and premiums, and limit plan availability particularly in rural areas. A commenter noted their belief that CMS' proposed policy seems at odds with CMS' stated concern about policies favoring one plan type over the other in the Proposed 2025 MA and Part D Rule.

A few commenters were concerned that the separate normalization factors would cause market disruption, with several commenters mentioning that this proposal is happening at a time when the effects of the Part C model phase-in will continue to put additional pressure on revenues for MA-PD plans.

Response: CMS appreciates the comments. The goal of the proposed normalization factors for the RxHCC models is not to favor one type of plan over another, but rather to more reasonably account for the diverging underlying risk score trends that occur between the model denominator year and the payment year for MA-PD plans and PDPs, in relationship to their respective costs. Average risk score can vary from a 1.0 average over time for a number of reasons, including changes in demographic characteristics, health status, and coding practices. As noted in the CY 2025 Advance Notice, MA-PD plans and PDPs are distinct in their cost, coding, and utilization patterns and there have been shifts in MA-PD and PDP risk scores over the past eight years since the inclusion of MA-PD plan data in the RxHCC model calibration in 2016. Our analysis showed that the proposed RxHCC model, updated to reflect the IRA redesign of the Part D benefit, predicted perfectly at the Part D market level, but the model tended to overpredict MA-PD plan costs (predictive ratio of 1.106) and underpredict PDP costs (predictive ratio of 0.879).

The RxHCC risk adjustment model is used to help ensure that payments to Part D plans reflect the plans' expected drug costs given their enrolled population. The model is used to calculate beneficiary risk scores, which reflect expected plan liability for drug costs compared to the average-cost beneficiary. In light of the significant increase in Part D plan liability for CY 2025 due to the IRA's redesign of the Part D benefit, with direct subsidy payments covering higher plan liability, the risk adjustment model that is used to calculate such payments is more important to Part D sponsors' total revenue. By separating the RxHCC normalization factors by market segment, CMS is able to more reasonably predict what the average risk score is likely to be for MA-PD plans versus PDPs by accounting for the distinct risk score trends between the two market sectors. In so doing, CMS more accurately predicts costs and creates a more level playing field that promotes fair competition between MA-PD plans and PDPs and beneficiary choice.

Comment: A commenter questioned whether the PDP normalization factor would apply to 1876 cost plans. The commenter pointed out that risk score to net plan liability relationship in 1876 cost plans is more like a PDP than MA-PD plan, which would make the PDP normalization factor most appropriate for this population.

Response: CMS appreciates the comment. The normalization factor for MA-PD plans will be applied to 1876 cost plans. Treatment of 1876 cost plans in this manner is consistent with how such plans are treated in the growth rates used in the calculation of the MA rates. Although 1876 cost plans do not receive risk-adjusted payments for covering medical services, but instead cost-reconciled payments, 1876 cost plans, like MA-PD plans, submit diagnoses for beneficiaries enrolled in their plans whereas diagnoses for beneficiaries enrolled in standalone PDPs are reported on FFS claims. By using separate normalization factors for MA-PD plans and PDPs, risk scores will more accurately reflect Part D costs in each of these two sectors of the Part D market that are driven by a variety of market-based variables, including the overall benefits that they are able to manage, the lack of an ability of PDPs to affect the submission of diagnoses in FFS, and available strategies used to manage Part D costs.

Comment: A commenter believed that with CMS not having a 2023 risk score for the RxHCC normalization factor calculation and not enough data for post-COVID-19 pandemic risk scores available to evaluate the accuracy of the modeling, there is apt to be distortion in the normalization factors.

Response: Because CMS incorporates risk scores from MA and FFS in calculation of normalization factors for the RxHCC models, the availability of risk scores used to calculate RxHCC model normalization factors are lagged one year relative to CMS-HCC risk scores. This has long been the case. CMS uses the data available at the time when calculating normalization factors, which for the RxHCC models for CY 2025 is 2022. We agree with the commenter that there was a limitation in our ability to model the multiple linear regression methodology that was proposed for the CMS-HCC model because we do not have a 2023 risk score for the RxHCC normalization factor calculation. It was for that reason that CMS did not believe it was prudent to alter the methodology at this time. The proposed methodology for calculating the CY 2025 normalization factors for the RxHCC models is akin to the methodology used for calculating the CY 2024 normalization factors for the CMS-HCC models when the 2022 risk score was the most recent data available and results in a reasonable estimate of what the average risk scores are likely to be in the payment year.

Comment: A couple of commenters had concerns with CMS' approach and assumptions made in the proposal for separate MA-PD and PDP normalization factors. Several commenters stated that CMS assumes that risk score trends observed in the MA-PD and PDP populations under the prior Part D benefit design will continue in 2025 under the newly redesigned Part D benefit, but they

believe this assumption is not supported by evidence and subject to a large degree of uncertainty, as the structure of the Part D benefit in 2025 is materially different from the perspective of both beneficiary and plan liability. A couple of commenters were concerned that there is not enough evidence to appropriately conclude that different normalization factors between MA-PD plans and PDPs are justified, or that the factors are accurate.

Several commenters requested that CMS consider alternatives to the proposed approach. For example, a few commenters suggested CMS should have separate RxHCC models for MA-PD plans and PDPs, and a commenter believed that the underlying differences between MA-PD and PDP risk score trends are driven by the discrepancy between the claims data that MA-PD plans and standalone PDPs have access to for coding and believed that a solution would be to allow standalone PDPs to have access to more complete and timely data.

Many commenters suggested that CMS should phase in the implementation of separate normalization factors or delay implementation until the risk score trends under the redesigned Part D benefit and RxHCC model can be assessed. A commenter requested that going forward, CMS include more time for policy proposal review and transparency in the data provided to stakeholders so that they can better analyze the policy proposal in order to take a specific position on the policy.

Response: CMS appreciates the feedback and concerns of the commenters. As discussed above, given the much greater importance of risk adjustment in Part D payment due to the significant change to plan liability under the IRA redesign of the Part D benefit in CY 2025, and a trend of growing divergence in risk scores between PDPs and MA-PD plans in relationship to their costs, CMS does not believe that the resulting unlevel playing field that generally inhibits fair competition between MA-PD plans and PDPs is sustainable.

In regards to whether risk score trends observed in the MA-PD and PDP populations under the prior Part D benefit design will continue in 2025 under the newly redesigned Part D benefit, CMS will continue to monitor MA-PD and PDP risk score trends and conduct analyses on the effects of the changes to the Part C and Part D models and benefit design, to determine the best approaches to normalization methodology in future years.

CMS acknowledges that there is inherent uncertainty in our normalization factors because they are projections of the payment year risk scores, and any projection can be imprecise. However, we base our normalization factors on the data available to us at the time, which was provided in Tables III-11 through III-13 in the CY 2025 Advance Notice, and whether or not the risk score projected (i.e., the normalization factor) is a reasonable estimate of the payment year risk score based on observed historical risk scores.

We do not believe that phasing in the separate MA-PD and PDP normalization factors is reasonable, given the large change to the Part D benefit and associated plan liability in CY 2025, and the increased importance of risk adjustment in calculating Part D payment.

We acknowledge the commenters' request for more time to review the policy proposals. Per section 1853(b)(2) of the Act, the Advance Notice of proposed changes to the methodology and assumptions used to determine annual MA capitation rates and the risk and other factors used in adjusting MA capitation rates under section 1853(a)(1)(C) is required to have a minimum 30-day comment period. Section 1860D-15(c)(1)(D) of the Act requires that CMS publish the risk adjustment factors for Part D at the time of publication of risk adjustment factors for Part C, which we propose in the Advance Notice and finalize in the Rate Announcement for the applicable year, per 423.329(b)(4). The CY 2025 Advance Notice was released on January 31st, 2024, and comments were accepted through 6 PM Eastern Time on Friday March 1, 2024 (30 days).

CMS believes that the period provided for comments on the CY 2025 Advance Notice is sufficient. In setting these timelines, we seek to achieve multiple goals, including providing the statutory-required amount of time for public comment while also releasing the Advance Notice using more current data to calculate the risk and other factors used to adjust MA capitation rates and ensuring that the Rate Announcement is published by the statutory deadline.

Comment: Some commenters believed that the proposed separate normalization factors could create distortions in the market, such as plan steerage or market consolidation. Several commenters believed that these financial incentives could possibly cause beneficiaries to be steered towards PDPs, since they may be more profitable there, even when their care options would be better under an MA-PD plan.

Several commenters had concerns about EGWPs in particular, as well as individual plans that allow for splitting of coverage between MA-only and PDP. They believed that separate normalization factors would incentivize groups to split MA and Part D benefits. Commenters believed that the best overall coordination of care for members is when the medical and drug benefits are integrated within one plan, and that having split plans would worsen enrollee care and experience.

The commenters made several suggestions regarding how the normalization factors could be applied to prevent potential splitting of coverage in EGWPs. One commenter suggested either applying the PDP factors to all EGWP beneficiaries, or to not apply the PDP factor to EGWP beneficiaries who also have at least one month of Part C experience during the year. Another commenter had several suggestions: require EGWP PDPs to use the MA-PD normalization factor; only have one Part D normalization factor for both MA-PD plans and PDPs; consider having two completely separate models for PDPs and MA-PD plans; restrict MA-PD EGWPs

from moving to a standalone PDP (EGWPs currently in a PDP should be grandfathered if this happens); require any MA-PD EGWP who transfers to a PDP to maintain the MA-PD normalization factor. Another commenter suggested that the Part D normalization factor should be based on whether a member is in FFS versus MA/MA-PD in the data collection period and not the plan type for the contract year, and an interim solution at the plan level to apply the MA-PD normalization factor to the PDP risk scores whenever beneficiaries are enrolled in both an MA-only plan and a PDP.

Response: CMS appreciates the feedback and concerns of the commenters. Per Section 1860D-1(a)(1)(B)(ii) of the Act and § 423.30(b), a Medicare-eligible person who is enrolled in an MA plan may not be simultaneously enrolled in a standalone PDP except in limited circumstances, such as if the individual is enrolled in a PFFS or MSA plan. CMS also waives this requirement for EGWPs meeting certain conditions. Therefore, if a non-EGWP MA-PD plan steers a beneficiary into a PDP owned by the same entity, the entity would be forgoing significant revenue that it would receive for providing medical coverage in MA. Due to such financial downsides, CMS believes it unlikely MA-PD plans would be incentivized to steer beneficiaries to PDPs.

In contrast, an applicable waiver might alter the incentives for EGWPs. Per Chapter 9 of the Medicare Managed Care Manual and Chapter 12 of the Prescription Drug Benefit Manual, an employer/union sponsor may enroll their beneficiaries "in both 800-series regional PPO EGWPs and local coordinated care plan EGWPs and 800-series stand-alone PDPs, provided that separate medical and prescription drug vendors work closely together with the employer/union sponsor to provide coordinated care and disease management services between the MA and the PDP portion of the benefit." Due to financial incentives, an employer/union sponsor may decide to enroll their beneficiaries in separate plans for their medical and prescription drug benefits. We emphasize, however, that as a condition of this waiver, that MA organizations and Part D sponsors are to work with employers to provide coordinated care and disease management services between the medical and prescription drug benefits offered by the MA-only EGWP and the stand-alone PDP EGWP. CMS will continue to monitor trends and conduct analyses to determine if additional adjustments need to be made to policy.

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

Please refer to Attachment III, Section O. for comments and responses regarding sources of diagnoses.

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

**Table V-1. Updated API and CPI for 2025**

| | Annual percentage trend for 2024 | Prior year revisions | API for 2025 |
|---|---|---|---|
| API | 5.46% | 2.96% | 8.58% |
| September CPI (all items, U.S. city average) | 2.61% | -0.11% | 2.50% |

**Table V-2. Updated Part D Benefit Parameters for Defined Standard Benefit, Low-Income Subsidy (LIS) and Retiree Drug Subsidy**

| | 2024 | 2025[26] |
|---|---|---|
| **Standard Benefit** | | |
| 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) Beneficiaries (2)** | | |
| 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] (3) | $0.00 | $0.00 |
| Maximum Copayments for Non-Institutionalized Beneficiaries | | |
| Up to or at 100% Federal Poverty Level (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% of FPL [category code 1] | | |
| Up to Out-of-Pocket Threshold | | |
| Generic/Preferred Multi-Source Drug | $4.50 | $4.90 |
| Other | $11.20 | $12.15 |

[26] These parameters reflect additional plan coverage required for covered insulin products under section 1860D-2(b)(9) of the Act, as added by section 11406 of the IRA, and ACIP-recommended adult vaccines under section 1860D-2(b)(8) of the Act, as added by section 11401 of the IRA.

| | 2024 | 2025[26] |
|---|---|---|
| **Full Subsidy-Non-FBDE Beneficiaries (2)** | | |
| Applied or eligible for QMB/SLMB/QI or SSI, income at or below 150 % FPL for 2024 and resources ≤ $15,720 (individuals, 2024) or ≤ $31,360 (couples, 2024) [category code 1] (4) | | |
| 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 |

(1) The LIS eligibility categories and corresponding cost-sharing benefits are sometimes referred to using category codes as follows:

- Category Code 1 – Non-institutionalized FBDE beneficiaries with incomes between 100 percent and 150 percent of FPL and full-subsidy-non-FBDE beneficiaries.
- Category Code 2 – Non-institutionalized FBDE beneficiaries with incomes up to 100 percent of the FPL.
- Category Code 3 – FBDE beneficiaries who are institutionalized or would be institutionalized if they were not receiving home and community-based services.
- Category Code 4 –Beneficiaries with incomes between 135 percent and 150 percent of the FPL, who meet the resource standards under either of sections 1860D-14(a)(3)(D) or (E) of the Act, and who would have been eligible for the partial LIS benefit absent the enactment of the IRA, will be eligible for the full LIS benefit. Beneficiaries who previously met the resource requirement for category 4 will be in category 1 in CY 2025.

(2) Per section 1860D-14(a)(1)(D)(i) of the Act, full-benefit dually eligible beneficiaries who are receiving home and community-based services qualify for zero cost sharing if the individuals (or couple) would have been institutionalized otherwise.

(3) The resource limits for CY 2025 will be provided via the annual HPMS memo entitled "2025 Resource and Cost-Sharing Limits for Low-Income Subsidy (LIS)" that is expected to be released during the usual timeframe after the September 2024 CPI has been made available by the Bureau of Labor Statistics. Additionally, these amounts are adjusted for beneficiaries that notified the Social Security Administration of their intent to use a portion of their resources for burial expenses. The CY 2024 resource limits including $1,500 per person for burial expenses are $17,220 ($34,360 if married). Also, beneficiaries that would have been eligible for the partial LIS

benefit had the IRA not been enacted will be eligible for the full LIS benefit if they meet the resource standard described at section 1860D-14(a)(3)(E) of the Act.[27]

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

***Annual Percentage Increase in Consumer Price Index, September (September CPI)***

Section 1860D-14(a)(4) of the Act requires CMS to use the annual percentage increase in the CPI for the 12-month period ending in September 2024 to update the maximum copayments up to the annual OOP threshold for full-benefit dually eligible beneficiaries with incomes not exceeding 100 percent of the FPL for CY 2025. These copayments are increased from $1.55 per generic, preferred drug that is a multi-source drug, or biosimilar, and from $4.60 for all other drugs in CY 2024 and rounded to the nearest multiple of $0.05 and $0.10 respectively.[28]

**Section B. Calculation Methodology**

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

For contract years 2006 and 2007, the APIs, as defined in section 1860D-2(b)(6) of the Act, were based on the National Health Expenditure (NHE) prescription drug per capita estimates because sufficient Part D program data was not available. Beginning with contract year 2008, the APIs are based on Part D program data. For the CY 2025 benefit parameters, Part D program data will be used to calculate the annual percentage trend as follows:

$$\frac{August\ 2023 - July\ 2024}{August\ 2022 - July\ 2023} = \$5{,}338.49/\$5{,}062.28 = 1.0546$$

In the formula, the average per capita cost for August 2022 – July 2023 is calculated from actual Part D PDE data, and the average per capita cost for August 2023 – July 2024 is calculated based on actual Part D PDE data for prescription drug claims with service dates from August 2023 – December 2023 and projected through July 2024.

The 2025 benefit parameters reflect the 2024 annual percentage trend, as well as updates for revision to prior year estimates for API. Based on updated NHE prescription per capita costs and PDE data, the annual percentage increases are now calculated as summarized by Table V-3.

[27] Effective January 1, 2024, Section 11404 of the IRA expanded eligibility of the full LIS group to individuals with incomes between 135 and 150 percent of the FPL and who meet the statutory resource standards at either of sections 1860D-14(a)(3)(D) or (E) of the Act.

[28] Per section 1860D-14(a)(4)(A) of the Act, the copayments are increased from the unrounded 2024 values of $1.55 for multi-source generic or preferred drugs, and $4.65 for all other drugs.

**Table V-3. Revised Prior Years' Annual Percentage Trends**

| Year | Prior Estimates of Annual Percentage Trend | Revised Annual Percentage Trend |
|---|---|---|
| **2006** | 7.30% | 7.30% |
| **2007** | 5.92% | 5.92% |
| **2008** | 4.69% | 4.69% |
| **2009** | 3.14% | 3.14% |
| **2010** | 2.36% | 2.36% |
| **2011** | 2.15% | 2.15% |
| **2012** | 2.53% | 2.53% |
| **2013** | -3.14% | -3.14% |
| **2014** | 10.12% | 10.12% |
| **2015** | 9.89% | 9.89% |
| **2016** | 4.02% | 4.02% |
| **2017** | 1.87% | 1.87% |
| **2018** | 4.05% | 4.06% |
| **2019** | 4.92% | 4.92% |
| **2020** | 5.06% | 5.06% |
| **2021** | 4.69% | 4.69% |
| **2022** | 7.37% | 7.36% |
| **2023** | 6.42% | 9.57% |

Accordingly, the CY 2025 benefit parameters reflect a multiplicative update of 2.96 percent for prior year revisions. In summary, the 2024 parameters outlined in Section A are updated by 8.58 percent for 2025, as summarized by Table V-4.

**Table V-4. Annual Percentage Increase**

| | |
|---|---|
| Annual percentage trend for July 2024 | 5.46% |
| Prior year revisions | 2.96% |
| Annual percentage increase for 2025 | 8.58% |

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

***Annual Percentage Increase in Consumer Price Index, September (September CPI)***

To ensure that plan sponsors and CMS have sufficient time to incorporate cost-sharing requirements into the development of the benefit, any marketing materials, and necessary

systems, CMS includes in its methodology to calculate the annual percentage increase in the CPI for the 12-month period ending in September 2024, an estimate of the September 2024 CPI based on projections from the President's FY2025 Budget.

The September 2023 value is from the Bureau of Labor Statistics. The annual percentage trend in the September CPI for CY 2025 is calculated as follows:

$$\frac{Projected\ September\ 2024\ CPI}{Actual\ September\ 2023\ CPI} \text{ or } \$315.8/\$307.8=1.0261$$

(Source: President's FY2025 Budget and Bureau of Labor Statistics, Department of Labor)

The CY 2025 benefit parameters reflect the CY 2024 annual percentage trend in the September CPI of 2.61 percent, as well as a -0.11 percent multiplicative correction for the revision to last year's estimate. The CY 2024 annual percentage trend in the CPI can be found in Table V-5 below.

**Table V-5. Cumulative Annual Percentage Increase in September CPI**

| | |
|---|---|
| Annual percentage trend for September 2024 | 2.61% |
| Prior year revisions | -0.11% |
| Annual percentage increase for 2025 | 2.50% |

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

## Section C. Annual Percentage Increase in Average Expenditures for Part D Drugs Per Eligible Beneficiary

Section 1860D-2(b)(6) of the Act defines the API as "the annual percentage increase in average per capita aggregate expenditures for covered Part D drugs in the United States for Part D eligible individuals, as determined by the Secretary for the 12-month period ending in July of the previous year using such methods as the Secretary shall specify." The following defined standard Part D prescription drug benefit parameters are updated using the "annual percentage increase":

For CY 2025, the defined standard deductible amount is updated by multiplying the 2024 amount of $545 by the 2025 API and rounding to the nearest multiple of $5. Under section 1860D-2(b)(4)(B)(i)(VII) of the Act, the annual OOP threshold is statutorily set at $2,000 for CY 2025.

**Table V-6. Part D Benefit Parameters for Defined Standard Benefit for CY 2024 and CY 2025 for Non-LIS Beneficiaries[29]**

| | 2024 | | 2025 | |
|---|---|---|---|---|
| **Deductible Phase** | Cost sharing: 100% | | Cost sharing: 100% | |
| | Deductible: $545 | | Deductible: $590 | |
| **Initial Coverage Phase** | Cost sharing: 25% | | Applicable Drugs<br>Cost sharing: 25% | Non-applicable Drugs<br>Cost sharing: 25% |
| | Initial Coverage Limit: $5,030 | | Initial Coverage Limit: Not Applicable | |
| **Coverage Gap** | Applicable Drugs:<br>Cost sharing: 25% | Non-applicable Drugs<br>Cost sharing: 25% | N/A | |
| | Out-of-Pocket Threshold: $8,000 | | Out-of-Pocket Threshold: $2,000 | |

**Section D. Retiree Drug Subsidy Amounts**

While the IRA significantly redesigned the Part D benefit for 2025, the IRA did not change the statutory requirements for retiree drug subsidy plans (as defined in section 1860D-22 of the Act). Specifically, the IRA did not change the requirements related to the methodology for calculating the cost limit and threshold for the CY 2025 retiree drug subsidy amounts for retiree drug subsidy plans.[30]

Per section 1860D-22(a)(3)(B) of the Act and § 423.886(b)(3), the cost threshold and cost limit for qualified retiree prescription drug plans are updated using the API, as defined previously in this document.[31] The updated cost threshold is rounded to the nearest multiple of $5 and the updated cost limit is rounded to the nearest multiple of $50. The cost threshold and cost limit are defined as $545 and $11,200, respectively, for plans that end in CY 2024, and as $590 and $12,150 for plans that end in CY 2025, as noted in Table V-7.

[29] These parameters reflect additional plan coverage required for covered insulin products under section 1860D-2(b)(9) of the Act, as added by section 11406 of the IRA, and ACIP-recommended adult vaccines under section 1860D-2(b)(8) of the Act, as added by section 11401 of the IRA.

[30] Please see the Final CY 2025 Part D Redesign Program Instructions published concurrently with this Rate Announcement.

[31] The cost threshold is the amount of gross retiree costs that a retiree must incur before the retiree drug subsidy applies. The cost limit is the maximum amount of gross retiree costs that the retiree drug subsidy will cover after a retiree hits the cost threshold.

**Table V-7. Updated Retiree Drug Subsidy Amounts in CY 2025**

| | 2024 | 2025 |
|---|---|---|
| **Retiree Drug Subsidy Amounts** | | |
| Cost Threshold | $545 | $590 |
| Cost Limit | $11,200 | $12,150 |

## Attachment VI. Updates for Part C and D Star Ratings

### Part C and D Star Ratings and Future Measurement Concepts

The Part C and D Star Ratings measure the quality of and reflect the experiences of beneficiaries in MA and Prescription Drug Plans (PDPs or Part D plans), assist beneficiaries in finding the best plan for their needs, and determine eligibility for MA Quality Bonus Payments. The Star Ratings support CMS' efforts to make the patient the focus in all of our programs and to create incentives to eliminate health disparities.

The methodology for the Star Ratings system for the Part C and D programs is codified at §§ 422.160 - 422.166 and 423.180 - 423.186. In the Advance Notice, we provided information and updates as required by §§ 422.164(c)(2), (d), (e)(2) and (f)(1); 422.166(f)(2); 423.184(c)(2), (d), (e)(2), and (f)(1); and 423.186(f)(2). We reviewed the comments and will consider them as we identify future enhancements to the Star Ratings program.

### Reminders for 2025 Star Ratings

We provide various datasets and reports to plan sponsors throughout the year. Part C and D sponsors should regularly review their underlying measure data that are the basis for the Star Ratings and immediately alert CMS if errors or anomalies are identified so any issues can be resolved prior to the first plan preview period.

As described at §§ 422.164(h) and 423.184(h), CMS annually sets and announces a deadline for MA and Part D organizations to request that CMS or the Independent Review Entity (IRE) review its Part C appeals data or CMS review its Complaints Tracking Module (CTM) data. CMS is announcing a deadline of June 28, 2024, for all contracts to make their requests for review of the 2023 appeals and CTM measure data for the 2025 Star Ratings. Sponsoring organizations can view and monitor their Part C appeals timeliness and effectuation compliance data on the Medical Appeal Search website. Sponsoring organizations should refer to the May 10, 2019, HPMS memorandum, "Complaints Tracking Module (CTM) File Layout Change and Updated Standard Operating Procedures," for instructions on how to submit a Plan Request in HPMS to request a review of CTM complaint(s).

As a reminder, in the 2024 Rate Announcement, CMS stated that we will remove the question "In the last 6 months, how often did you see the person you came to see within 15 minutes of your appointment time?" from the Getting Appointments and Care Quickly measure for the 2025 Star Ratings. As explained in the CY 2024 Rate Announcement, this is a non-substantive change under § 422.164(d)(1). This will reduce the Getting Appointments and Care Quickly measure to the following existing two questions for the 2025 Star Ratings:

- In the last 6 months, when you needed care right away, how often did you get care as soon as you needed?
- In the last 6 months, how often did you get an appointment for a check-up or routine care as soon as you needed?

**Measure Updates for 2025 Star Ratings**

The measures that will be used to calculate the 2025 Star Ratings are listed in Table VI-1 with information about the measure type, weight, and measurement year. As a reminder, starting with the 2024 measurement year (2026 Star Ratings), the weight of patients' experience and complaints and access measures will be reduced to 2.[32]

**Table VI-1. 2025 Star Ratings Measures**

| Part C or D | Measure | Measure Type | Weight | Measurement Year | Improvement Measure | Included in the 2025 CAI Values |
|---|---|---|---|---|---|---|
| C | Breast Cancer Screening | Process Measure | 1 | 1/1/2023 – 12/31/2023 | **Yes** | **Yes** |
| C | Colorectal Cancer Screening | Process Measure | 1 | 1/1/2023 – 12/31/2023 | **Yes** | **Yes** |
| C | Annual Flu Vaccine | Process Measure | 1 | 3/2024 – 6/2024 | **Yes** | **Yes** |
| C | Controlling Blood Pressure | Intermediate Outcome Measure | 3 | 1/1/2023 – 12/31/2023 | **Yes** | **Yes** |
| C | Monitoring Physical Activity | Process Measure | 1 | 7/2023 – 11/2023 | **Yes** | **Yes** |
| C | Special Needs Plan (SNP) Care Management | Process Measure | 1 | 1/1/2023 – 12/31/2023 | **Yes** | **No** |
| C | Care for Older Adults – Medication Review | Process Measure | 1 | 1/1/2023 – 12/31/2023 | **Yes** | **No** |
| C | Care for Older Adults– Pain Assessment | Process Measure | 1 | 1/1/2023 – 12/31/2023 | **Yes** | **No** |

[32] Refer to CMS' CY 2024 Final Rule (CMS-4201-F).

| Part C or D | Measure | Measure Type | Weight | Measurement Year | Improvement Measure | Included in the 2025 CAI Values |
|---|---|---|---|---|---|---|
| C | Osteoporosis Management in Women who had a Fracture | Process Measure | 1 | 1/1/2023 – 12/31/2023 | **Yes** | **Yes** |
| C | Diabetes Care – Eye Exam | Process Measure | 1 | 1/1/2023 – 12/31/2023 | **Yes** | **Yes** |
| C | Diabetes Care – Blood Sugar Controlled | Intermediate Outcome Measure | 3 | 1/1/2023 – 12/31/2023 | **Yes** | **Yes** |
| C | Reducing the Risk of Falling | Process Measure | 1 | 7/2023 – 11/2023 | **Yes** | **Yes** |
| C | Improving Bladder Control | Process Measure | 1 | 7/2023 – 11/2023 | **Yes** | **Yes** |
| C | Medication Reconciliation Post-Discharge | Process Measure | 1 | 1/1/2023 – 12/31/2023 | **Yes** | **Yes** |
| C | Plan All-Cause Readmissions | Outcome Measure | 3 | 1/1/2023 – 12/31/2023 | **Yes** | **Yes** |
| C | Transitions of Care | Process Measure | 1 | 1/1/2023 – 12/31/2023 | **Yes** | **Yes** |
| C | Follow-up after Emergency Room Visit | Process Measure | 1 | 1/1/2023 – 12/31/2023 | **Yes** | **Yes** |
| C | Getting Needed Care | Patients' Experience and Complaints Measure | 4 | 3/2024 – 6/2024 | **Yes** | **No** |
| C | Getting Appointments and Care Quickly | Patients' Experience and Complaints Measure | 4 | 3/2024 – 6/2024 | **Yes** | **No** |

| Part C or D | Measure | Measure Type | Weight | Measurement Year | Improvement Measure | Included in the 2025 CAI Values |
|---|---|---|---|---|---|---|
| C | Customer Service | Patients' Experience and Complaints Measure | 4 | 3/2024 – 6/2024 | **Yes** | **No** |
| C | Rating of Health Care Quality | Patients' Experience and Complaints Measure | 4 | 3/2024 – 6/2024 | **Yes** | **No** |
| C | Rating of Health Plan | Patients' Experience and Complaints Measure | 4 | 3/2024 – 6/2024 | **Yes** | **No** |
| C | Care Coordination | Patients' Experience and Complaints Measure | 4 | 3/2024 – 6/2024 | **Yes** | **No** |
| C | Complaints about the Health Plan | Patients' Experience and Complaints Measure | 4 | 1/1/2023 – 12/31/2023 | **Yes** | **No** |
| C | Members Choosing to Leave the Plan | Patients' Experience and Complaints Measure | 4 | 1/1/2023 – 12/31/2023 | **Yes** | **No** |
| C | Health Plan Quality Improvement | Improvement Measure | 5 | NA | **No** | **No** |
| C | Plan Makes Timely Decisions about Appeals | Measures Capturing Access | 4 | 1/1/2023 – 12/31/2023 | **Yes** | **No** |
| C | Reviewing Appeals Decisions | Measures Capturing Access | 4 | 1/1/2023 – 12/31/2023 | **Yes** | **No** |

| Part C or D | Measure | Measure Type | Weight | Measurement Year | Improvement Measure | Included in the 2025 CAI Values |
|---|---|---|---|---|---|---|
| C | Call Center – Foreign Language Interpreter and TTY Availability | Measures Capturing Access | 4 | 2/2024 – 5/2024 | **Yes** | **No** |
| C | Statin Therapy for Patients with Cardiovascular Disease | Process Measure | 1 | 1/1/2023 – 12/31/2023 | **Yes** | **Yes** |
| D | Call Center – Foreign Language Interpreter and TTY Availability | Measures Capturing Access | 4 | 2/2024 – 5/2024 | **Yes** | **No** |
| D | Complaints about the Drug Plan | Patients' Experience and Complaints Measure | 4 | 1/1/2023 – 12/31/2023 | **Yes** | **No** |
| D | Members Choosing to Leave the Plan | Patients' Experience and Complaints Measure | 4 | 1/1/2023 – 12/31/2023 | **Yes** | **No** |
| D | Drug Plan Quality Improvement | Improvement Measure | 5 | NA | **No** | **No** |
| D | Rating of Drug Plan | Patients' Experience and Complaints Measure | 4 | 3/2024 – 6/2024 | **Yes** | **No** |
| D | Getting Needed Prescription Drugs | Patients' Experience and Complaints Measure | 4 | 3/2024 – 6/2024 | **Yes** | **No** |
| D | MPF Price Accuracy | Process Measure | 1 | 1/1/2023 – 9/30/2023 | **Yes** | **No** |

| Part C or D | Measure | Measure Type | Weight | Measurement Year | Improvement Measure | Included in the 2025 CAI Values |
|---|---|---|---|---|---|---|
| D | Medication Adherence for Diabetes Medications | Intermediate Outcome Measure | 3 | 1/1/2023 – 12/31/2023 | **Yes** | **Yes** |
| D | Medication Adherence for Hypertension (RAS antagonists) | Intermediate Outcome Measure | 3 | 1/1/2023 – 12/31/2023 | **Yes** | **Yes** |
| D | Medication Adherence for Cholesterol (Statins) | Intermediate Outcome Measure | 3 | 1/1/2023 – 12/31/2023 | **Yes** | **Yes** |
| D | MTM Program Completion Rate for CMR | Process Measure | 1 | 1/1/2023 – 12/31/2023 | **Yes** | **Yes** |
| D | Statin Use in Persons with Diabetes | Process Measure | 1 | 1/1/2023 – 12/31/2023 | **Yes** | **Yes** |

**Improvement Measures (Part C & D) for the 2025 Star Ratings**

Under §§ 422.164(f) and 423.184(f), improvement measures are calculated using performance measures that meet specific conditions. Table VI-1 includes information about which measures will be used to calculate the improvement measures for the 2025 Star Ratings. As stated in §§ 422.164(f)(4)(i) and
423.184(f)(4)(i), CMS will only include measures in the improvement calculations at the contract level if numeric value scores are available for both the current and prior year.

**2025 Star Ratings Program and the Categorical Adjustment Index**

The methodology for the Categorical Adjustment Index (CAI) is described at §§ 422.166(f)(2) and 423.186(f)(2), as well as in the annual Medicare Part C & D Star Ratings Technical Notes available on CMS' Part C and D Star Ratings website. As finalized at §§ 422.166(f)(2) and 423.186(f)(2), all measures identified as candidate measures will be included in the determination of the 2025 CAI values. The measure set for the 2025 CAI (for both Part C and D) is identified in Table VI-1.

In keeping with our commitment to transparency, a summary of the analysis of the candidate measure set that includes the minimum, median, and maximum values for the within-contract

variation for the low-income subsidy (LIS)/dual eligible (DE) differences are posted with the 2025 CAI values on CMS' Part C and D Star Ratings website.

**Extreme and Uncontrollable Circumstances Policy for the 2025 Star Ratings**

Extreme and uncontrollable circumstances such as natural disasters can directly affect Medicare beneficiaries and providers, as well as the Parts C and D organizations that provide beneficiaries with important medical care and prescription drug coverage. An affected contract is identified based on these criteria:

> (1) Its service area is within an "emergency area" during an "emergency period" as defined in section 1135(g)(1) of the Act;
>
> (2) Its service area is within a geographic area designated in a major disaster declaration under the Stafford Act and the Secretary exercised authority under section 1135 of the Act based on the same triggering event(s); and
>
> (3) A certain minimum percentage (25 percent or 60 percent) of the enrollees under the contract must reside in a Federal Emergency Management Agency (FEMA)-designated Individual Assistance area at the time of the extreme and uncontrollable circumstance. (See §§ 422.166(i) and 423.186(i).)

We use the start date of the incident period to determine which year of Star Ratings could be affected, regardless of whether the incident period extends to another calendar year (§§ 422.166(i) and 423.186(i)).

Under the 25 percent rules at §§ 422.166(i)(2)–(6) and 423.186(i)(2)–(5), contracts with at least 25 percent of their service area in a FEMA-designated Individual Assistance area in 2023 will receive the higher of their measure-level rating from the current and prior Star Ratings years for purposes of calculating the 2025 Star Ratings (thus, for 2025 Star Ratings, affected contracts will receive the higher of their measure-level ratings from the 2024 rating or 2025 rating for the applicable measures). The numeric scores for contracts with 60 percent or more of their enrollees living in FEMA-designated Individual Assistance areas at the time of the extreme and uncontrollable circumstance are excluded from: (1) the measure-level cut point calculations for non-CAHPS measures; and (2) the performance summary and variance thresholds for the reward factor as described at §§ 422.166(i)(9)(i) and (i)(10)(i), and 423.186(i)(7)(i) and (i)(8)(i). As a reminder, starting with the 2026 Star Ratings that covers the 2024 measurement year for most measures, the 60 percent rule will be removed.[33] Table VI-2 lists the emergency areas affected by emergency declarations first issued in 2023, as

[33] Refer to CMS' CY 2024 Final Rule (CMS-4201-F).

defined in section 1135 of the Act, and the exercise of the Secretary's authority under section 1135 of the Act.

**Table VI-2. List of Section 1135 Waivers Issued in Relation to the FEMA Major Disaster Declarations**

| Section 1135 Waiver Date Issued | Waiver or Modification of Requirements Under Section 1135 of the Social Security Act | FEMA Incident Type | Affected State | Incident Start Date |
|---|---|---|---|---|
| March 27, 2023 | Severe Storms, Straight-Line Winds, and Tornadoes | Severe Storms, Straight-line Winds, and Tornadoes | Mississippi | Mar 24, 2023 |
| June 2, 2023 | Typhoon Mawar | Typhoon Mawar | Guam | May 22, 2023 |
| August 11, 2023 | Wildfires | Wildfires | Hawaii | August 8, 2023 |
| August 30, 2023 | Hurricane Idalia | Hurricane | Florida | August 27, 2023 |
| September 12, 2023 | Hurricane Idalia | Hurricane | Georgia | August 30, 2023 |

Table VI-3 lists the states and territories with Individual Assistance designations from the FEMA major disaster declarations.

**Table VI-3. Individual Assistance Counties and County-Equivalents in FEMA Major Disaster Declared States/Territories**

| FEMA Declaration | State | FEMA Individual Assistance Counties or County-Equivalents |
|---|---|---|
| DR-4697-MS | Mississippi | Carroll, Humphreys, Monroe, Montgomery, Panola, Sharkey |
| DR-4715-GU | Guam | Guam |
| DR-4724-HI | Hawaii | Maui |
| DR-4734-FL | Florida | Charlotte, Citrus, Columbia, Dixie, Gilchrist, Hamilton, Hernando, Hillsborough, Jefferson, Lafayette, Levy, Madison, Manatee, Pasco, Pinellas, Sarasota, Suwannee, Taylor |
| DR-4738-GA | Georgia | Berrien, Brooks, Cook, Glynn, Lowndes |

**Changes to Existing Star Ratings Measures for the 2025 Measurement Year and Beyond**

CMS solicits feedback on new measure concepts as well as measure updates through the annual Advance Notice and Rate Announcement process. We also provide advance notice regarding measures considered for implementation as future Star Ratings measures. As codified at §§ 422.164(c)(2)(4), 423.184(c)(2)(4), 422.164(d)(2), and 423.184(d)(2), new measures and measures with substantive specification changes must be added or updated through rulemaking and must remain on the display page for at least two years prior to becoming a Star Ratings measure. CMS uses the Advance Notice and Rate Announcement process to announce non-substantive specification changes as described at §§ 422.164(d)(1) and 423.184(d)(1) and to remove measures as described at §§ 422.164(e) and 423.184(e). We described a number of measure concepts and changes in the Advance Notice and summarize significant comments on those issues here. We encourage interested parties to provide comments directly to measure developers during their public comment periods. For example, the National Committee for Quality Assurance (NCQA) and the Pharmacy Quality Alliance (PQA) regularly solicit public comments on new measures, changes to existing measures, and measure retirements. We submitted the Initiation and Engagement of Substance Use Disorder Treatment (Part C) and Initial Opioid Prescribing for Long Duration (IOP-LD) (Part D) measures to the 2023 Pre-

Rulemaking Measure Review (PRMR) process, and we are reviewing the feedback[34] as we consider measures to propose to add to the Star Ratings through future rulemaking.

**Future Universal Foundation Star Ratings Measures.** As part of the CMS National Quality Strategy and Medicare Value-Based Care Strategy, CMS is committed to aligning a subset of measures across all our programs and ensuring we measure quality across the entire care continuum in a way that promotes the best, safest, and most equitable care for all individuals. Improving alignment of measures across federal programs and with private payers will reduce provider burden while also improving the effectiveness and comparability of measures across quality programs. Across our CMS quality rating and value-based care programs, where applicable, we are implementing the "Universal Foundation"[35] of quality measures which is a subset of measures that are aligned across programs. This "Universal Foundation" is a building block to which programs will add additional aligned or program-specific measures. As discussed in the 2024 Rate Announcement, we will add Depression Screening and Follow-Up for Adolescents and Adults (Part C) and Adult Immunization Status (Part C)[36] to the 2026 display page based on the 2024 measurement year. In the 2024 Advance Notice we solicited feedback regarding adding the Initiation and Engagement of Substance Use Disorder Treatment (Part C) measure to the Star Ratings in the future pending rulemaking. We submitted this measure through the 2023 PRMR process which provides recommendations to HHS on the selection of quality and efficiency measures for CMS programs. Adding this measure to the Part C Star Ratings would further align the Part C Star Ratings with the Universal Foundation. We are working to include all of the Universal Foundation measures[37] as part of the Part C and D Star Ratings pending future rulemaking.

Although there was overall support for the Universal Foundation, some commenters raised data collection challenges for the Initiation and Engagement of Substance Use Disorder Treatment, Depression Screening and Follow-up, Social Need Screening and Intervention, and Adult Immunization Status measures. Some commenters asked for time to prepare for implementation of these new measures. For the Initiation and Engagement of Substance Use Disorder Treatment measure, some of the challenges commenters noted include state and federal requirements regarding disclosure of alcohol and substance use disorder information without written authorization from the individual. For the Depression Screening and Follow-up measure,

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[34] Refer to information on the Pre-Rulemaking Measure Review (PRMR) process and the 2023 Final Measures Under Consideration (MUC) Recommendation Report.

[35] Jacobs, D. B., Schreiber, M., Seshamani, M., Tsai, D., Fowler, E., & Fleisher, L. A. (2023). Aligning quality measures across CMS—the universal foundation. New England Journal of Medicine, 388(9), 776-779.

[36] As guidelines develop around COVID-19, respiratory syncytial virus (RSV), and Hepatitis B vaccination, NCQA will assess and determine the appropriateness of incorporating these vaccine indicators in the Adult Immunization Status measure.

[37] The following Part C Star Ratings measures are part of the Universal Foundation: Breast Cancer Screening, Colorectal Cancer Screening, Controlling Blood Pressure, Diabetes Care – Blood Sugar Controlled, Plan All-Cause Readmissions, and CAHPS Overall Rating measures.

commenters raised issues about the availability of data needed, and the impact of state laws and regulations on the ability to share mental health information with primary care providers without patient consent and the effect this may have on providing follow-up care. Some commenters asked for more opportunities to provide input regarding which measures are part of the Universal Foundation, while a few commenters provided suggestions for additional measures such as the Kidney Health Evaluation measure. We appreciate the feedback as we continue to explore adding measures to the Star Ratings that are part of the Universal Foundation. As we add Social Need Screening and Intervention to the 2025 display page and Adult Immunization Status and Depression Screening and Follow-up to the 2026 display page, we will continue to examine data quality issues. We shared the feedback we received with NCQA for their consideration as they make updates to these measures.

**Breast Cancer Screening (Part C)**. The current Breast Cancer Screening measure assesses screening for members eligible for breast cancer screening aged 50-74. In May 2023, the U.S. Preventive Services Task Force (USPSTF) released a draft statement that recommends biennial mammography screening for women aged 40-74 years at average risk of breast cancer. In October 2023, NCQA sought public comment on revising the measure to assess screening for members aged 40-49, in addition to those 50-74, for the HEDIS Measurement Year 2024 Technical Update (released April 1, 2024). Commenters and other stakeholders advised NCQA to implement the proposed measure change after the USPSTF releases its final recommendation statement sometime in 2024. Thus, after the final recommendation is published, NCQA will consider adding individuals 40-49 years of age to the measure for all product lines for measurement year 2025. If this change is approved, NCQA plans to include two age strata – one for the legacy measure and one that includes the new age group. Adding an age group is a substantive measure specification change as described at § 422.164(d)(2); thus, the updated measure will be on the display page for two or more years and proposed through rulemaking prior to adding it to the Part C Star Ratings. We intend to keep the legacy measure in the Star Ratings while the new measure is on display.

We received similar comments on the Advance Notice as NCQA received during their public comment periods. Commenters were supportive of this proposed change, but some noted that it should follow the release of final recommendations of the USPSTF.

**Diabetes Care - Eye Exam (Part C)**. NCQA is evaluating the administrative codes used to determine that a diabetic retinal eye exam has been completed following feedback from the NCQA Geriatric Measurement Advisory Panel that it would be useful to have more specific codes in this measure. Based on this feedback and NCQA's strategic goal to move toward digital measures, NCQA reviewed the measure codes with their Diabetes Measurement Advisory Panel and plans to include updates for measurement year 2025. This update would be non-substantive

under § 422.164(d)(1)(iii) since it updates the clinical codes with no change to the target population or the intent of the measure.

Commenters provided mixed feedback on the updates to the codes for this measure, with some commenters wanting to better understand the coding changes to ensure no unintended consequences, while other commenters wanted to continue hybrid reporting for this measure, raising concerns that plans do not always receive claims for all eye exams. We shared the feedback we received with NCQA for their review.

**Statin Therapy for Patients with Cardiovascular Disease (Part C).** Over the past several years, NCQA has received questions related to how members experiencing statin intolerance might be excluded from this measure. In the absence of coding methods that accurately capture true statin intolerance, the measure currently excludes members with a diagnosed muscle condition during the measurement year as a proxy for statin intolerance. However, this exclusion does not address members who have a history of intolerance to statin medications who no longer have a qualifying muscle condition during the measurement year. Patients may go through an arduous statin rechallenging process to be deemed intolerant, which requires close monitoring and shared decision-making with the managing clinician to weigh the risks against the benefits of discontinuing statins. To allow the exclusion of such patients with a history of statin intolerance, NCQA plans to add the exclusion "myalgia or rhabdomyolysis caused by a statin at any time during the member's history through December 31 of the measurement year" and create a value set specifically for this exclusion. This exclusion was supported by members of NCQA's Cardiovascular Measurement Advisory Panel. NCQA plans to implement this update for measurement year 2025 and anticipates no significant impact on performance rates. This update would be non-substantive under § 422.164(d)(1)(i) because it narrows the population covered under the measure. NCQA is also planning a re-evaluation of the Statin Therapy for Patients with Cardiovascular Disease measure for measurement year 2026. Almost all commenters supported this update.

**Plan Makes Timely Decisions about Appeals and Reviewing Appeals Decisions (Part C)**. The timeliness measure evaluates the percent of appeals timely processed by the plan (numerator) out of all the plan's appeals decided by the Independent Review Entity (IRE) (includes upheld, overturned, partially overturned and appeals not evaluated by the IRE because the plan agreed to cover) (denominator). Given the extent to which cases are now submitted electronically (via the portal) to the IRE, CMS is considering updates to the Maximus Medicare Health Plan Reconsideration Process Manual Medicare Managed Care Reconsideration Project

(i.e., the IRE Manual)[38] to better align when submission of a case file to the IRE is considered timely with the existing regulations.

First, CMS is considering eliminating the additional days the IRE allows for appeal files that are submitted electronically. Currently, the IRE includes additional days to make allowances for any mail delays. Because the IRE now receives over 99 percent of case files electronically via the portal, CMS is considering updating the language in the IRE Manual to use a deadline for timely portal (that is, electronic) submission that aligns with the timeliness requirements in § 422.590 for submission of standard, expedited, and Part B drug cases. Section 422.590(a)(2) requires Medicare health plans to submit an unfavorable standard service reconsideration to the IRE as expeditiously as the enrollee's health condition requires, or not later than 30 calendar days after the receipt of a valid reconsideration request, subject to an additional 14-calendar day extension if in the enrollee's interest, per § 422.590(e). The regulations do not provide any additional time for mail delays and the IRE does not require Medicare health plans to use overnight delivery for non-expedited cases. For purposes of defining and calculating timeliness, the IRE currently adds five calendar days to the timeframes listed above for all appeal file submissions. For example, the IRE considers a standard service case, without an extension, to be submitted timely if it is received within 35 calendar days of the valid request for reconsideration; this means that for electronic submissions by the plan, the plan has an extra five days to submit the file to the IRE beyond the deadline established in the applicable regulation. CMS is considering eliminating this 5-day period for all cases submitted electronically. CMS believes this change is justified due to the overwhelming majority of cases being submitted electronically; further, eliminating the 5-day grace period for electronic submissions aligns this measure with the regulation text. The timeliness of case files submitted by mail would continue to be subject to the 5-day grace period. Please note these changes are only in effect for electronic submissions. For hard copies, the IRE considers a standard service case, without an extension, to be submitted timely if it is received within 35 calendar days outside of the IRE’s normal business hours.

The second update CMS is considering is to use the electronic system receipt date and time as the date the appeal was received by the IRE, regardless of whether it is during the IRE’s business hours, for electronic submissions. Currently, the IRE uses the system receipt date as the date the appeal was received if it is during the IRE’s normal business hours. If the system receipt date is outside of the IRE’s normal business hours, the following business day is used as the receipt date. For example, if the appeal is received on a Sunday when the IRE offices are closed, the appeal would be considered received on Monday when the offices are open. With this potential change the receipt date would be Sunday rather than Monday. CMS is considering updating the IRE Manual and process to allow case files submitted via the portal to be considered received on

[38] Refer to the Maximus Medicare Health Plan Reconsideration Process Manual Medicare Managed Care Reconsideration Project.

the date and time of portal submission, even if it is outside of normal business hours. This means that cases received up to 11:59 p.m. (Eastern Time) each day via the portal would be considered received on that day. (However, the processing timeframe for the IRE-level review would not commence until the following business day.) This update would more closely reflect the submission of electronic files than current practice. Please note these changes would only affect electronic submissions. If hard copies are delivered outside of the IRE's normal business hours, the following business day is used as the receipt date.

If these changes are made to the IRE Manual, this would impact how timeliness is defined for the Plan Makes Timely Decisions about Appeals measure. This potential change would also impact the Reviewing Appeals Decisions measure because the appeals used in this measure are based on the date in the calendar year the appeal was received by the IRE, and this potential update could affect the received date. If these changes are made to the IRE Manual, they would be highlighted on the Maximus website.

These potential changes would result in substantive measure updates under § 422.164(d)(2) because the IRE's processes for determining timeliness and the received date would change. In accordance with § 422.164(d)(2), substantive changes to existing measures will be proposed and finalized through rulemaking. If these substantive changes to the measures are proposed, the legacy appeals measures would remain in the Star Ratings until the updated measures have been on the display page for at least 2 years. Then, the legacy measures would be retired, and the re-specified appeals measures would move into the Star Ratings pending rulemaking.

The majority of commenters supported eliminating the grace period and using the electronic system receipt date as the date the appeal was received by the IRE. A couple of commenters asked for clarification regarding the grace periods for expedited and Part B appeals. Some commenters wanted a grace period ranging from 1 to 3 days to provide more time to review appeals cases before they are submitted to the IRE electronically. A few commenters asked that the Maximus portal indicate whether the appeal is submitted electronically or by mail. We appreciate the comments we received and will take them into consideration as we consider proposing changes through the rulemaking process. As we stated in the Advance Notice, CMS is considering updating the language in the IRE Manual to use a deadline for electronic submission that aligns with the timeliness requirements in § 422.590 for submission of standard, expedited, and Part B drug cases; thus, there would be no grace periods for any type of appeal to ensure that all appeals are resolved in a timely manner.

**Cross-cutting: Identifying Chronic Conditions (Part C)**. NCQA is continuing its reevaluation of how to identify those with chronic conditions across HEDIS measures with the goals of 1) updating the claims-based approach that is currently used to identify conditions and 2) developing a new method that provides directions for how to identify conditions using clinical

data. Measure specifications will be simplified to identify members with a condition if they have at least two encounters with the diagnosis (in any setting) on different dates of service. The changes replace the current method which requires at least two visits (e.g., outpatient, observation, telephone, emergency department, non-acute inpatient encounters) on different dates of service *or* at least one inpatient encounter or discharge with a diagnosis. For example, this method is also planned for a new blood pressure measure under development for HEDIS measurement year 2025. The planned blood pressure measure also allows for one encounter diagnosis and a dispensed anti-hypertensive medication. Finally, a method to identify conditions using clinical data is beginning to be developed and may require at least two encounters with a diagnosis, or an active diagnosis on the problem list within a specified time period. As this reevaluation work continues, there may be additional updates to the methods of identifying conditions that may impact measure denominators and exclusions across HEDIS measures. Most commenters were supportive of NCQA reevaluating how to identify those with chronic conditions, but some had additional questions or suggestions. We have shared the feedback we received with NCQA and will provide more information as NCQA continues to explore these potential updates in identifying enrollees with chronic conditions.

**Cross-cutting: Gender-Affirming Quality Measurement in HEDIS (Part C).** NCQA is expanding on the work they started for measurement year 2024 to evaluate approaches to update measure specifications where eligible populations are currently defined with gendered language to ensure inclusive and gender-affirming approaches aligned with measure intent and clinical evidence. The Star Ratings measures under consideration for potential changes focus on appropriate statin therapy and osteoporosis treatment. Evaluation of potential updates to gendered language in the Statin Therapy for Patients with Cardiovascular Disease measure would be conducted as part of NCQA's planned evaluation described above. The intent of this effort is to ensure that all members in need of, or recommended for, care are included in the eligible population, and to address potential disparities in access and outcomes for transgender and gender-diverse members. Commenters expressed overwhelming support for this effort. CMS shared the feedback we received with NCQA and will provide more information as NCQA continues to explore these potential updates, including the selection of measure(s) for revision.

**Care Coordination (Part C).** The Care Coordination measure is a composite measure based on six questions intended to measure the patient's experience with care coordination. We are considering updating two of the questions. As noted in the 2024 Rate Announcement, CMS tested some alternative questions for the Care Coordination measure derived from the CAHPS survey; the questions focused on how often doctors, nurses, or health care providers explain the results of tests, how often the explanations were easy to understand, and how often the information provided about test results was as much as was needed. Among the goals of the 2022 field test were to identify promising new items to (a) replace any existing care coordination items

that were no longer performing well psychometrically, (b) refresh the concept in a way that might include high performing, recently developed test result items, and (c) not appreciably increase the number of items on the survey.

Table VI-4 shows the items in the current and potential new composite measures. There are two items from the existing composite that are not part of the potential new composite. One of these items ("Did you get the help you needed from your personal doctor's office to manage care from different providers and services?") has response options that deviate from those of other items. The other is a test results item that is no longer needed given the new test results items we propose to incorporate. The remaining four items from the existing composite are also part of the potential new composite. There are two items in the potential new composite that are not part of the existing composite. Of the six items in the potential new composite, three pertain to test results and three pertain to other aspects of care coordination. All items on aspects of care coordination other than test results are in the current composite, although the wording of one of these items has been slightly modified.

**Table VI-4. Care Coordination Items in the Current and Potential New Composite**

| **Current Composite** | **Potential New Composite** |
|---|---|
| In the last 6 months, when your personal doctor ordered a blood test, x-ray, or other test for you, how often did you get those results as soon as you needed them? | N/A |
| In the last 6 months, did you get the help you needed from your personal doctor's office to manage your care among these different providers and services? | N/A |
| In the last 6 months, when you talked with your personal doctor during a scheduled appointment, how often did he or she have your medical records or other information about your care? | In the last 6 months, when you talked with your personal doctor during a scheduled appointment, how often did he or she have your medical records or other information about your care? |
| In the last 6 months, how often did you and your personal doctor talk about all the prescription medicines you were taking? | In the last 6 months, how often did you and your personal doctor talk about all the prescription medicines you were taking? |
| In the last 6 months, how often did your personal doctor seem informed and up to date about the care you got from specialists? | In the last 6 months, how often did your personal doctor seem informed and up to date about the care you got from specialists? |
| In the last 6 months, when your personal doctor ordered a blood test, x-ray, or other test for you, how often did someone from your personal doctor's office follow up to give you those results? | In the last 6 months, when a doctor, nurse, or other health care provider ordered a blood test, x-ray, or other test for you, how often did you get your test results? |

| | |
|---|---|
| N/A | In the last 6 months, how often did a doctor, nurse, or other health care provider explain the results of your blood test, x-ray, or other test? |
| N/A | In the last 6 months, how often did you get as much information as you needed about your test results? |

The potential six-item composite has a Cronbach's alpha of 0.77 (indicating good internal consistency) and contract-level reliability of 0.82 (indicating strong potential to distinguish contracts from one another).

In a regression analysis predicting overall rating of health plan (scored on a 0-100 scale) from this potential Care Coordination composite and the standard set of CAHPS case-mix adjustors, care coordination was a significant predictor, $b = 0.283$, $SD = 0.029$, $p < 0.001$, suggesting good criterion validity. This is an improvement upon the predictive validity of the current Care Coordination composite: $b = 0.078$, $SD = 0.001$, $p < 0.001$.

The current and potential new Care Coordination composite measures are strongly correlated at 0.76 – that is, contracts that did well on one typically did well on the other.

In sum, this potential new six-item Care Coordination composite has the following advantages:

- It has very good psychometric properties as demonstrated by the reliability, internal consistency, and criterion validity discussed above.
- It puts more emphasis on the important concept of test results (moving from two to three items).
- It does not increase respondent burden.
- We expect that contracts that did well on the current composite would continue to do well on the revised composite measure.

These changes to the Care Coordination measure would be a substantive update to the Star Ratings measure under § 422.164(d)(2).

Many commenters were supportive of the changes to the Care Coordination measure but had suggestions for changes to the language or to the number of questions included in the composite. Commenters asked for clarification on how the changes would impact scores and on the display page measure process for substantive updates for CAHPS measures. If these changes are made, the existing Care Coordination measure would be removed from the Star Ratings while the updated measure is on the display page for two years. We will take all comments into consideration as we work to update the Care Coordination measure. These changes to the Care Coordination measure would be a substantive update to the Star Ratings measure under § 422.164(d)(2).

**Initial Opioid Prescribing for Long Duration (IOP-LD) (Part D).** As part of CMS' efforts to address the national opioid crisis, we have implemented balanced drug utilization review (DUR) policies and quality measurement strategies to help prevent and reduce prescription opioid overuse in the Medicare Part D population while maintaining needed access. CMS began reporting the IOP-LD measure to Part D sponsors through the Patient Safety reports in measurement year 2020 and has publicly reported the measure on the Part D display page[39] since 2023 (2021 data). The PQA is the measure steward. In the 2021 Advance Notice, we solicited feedback regarding adding the IOP-LD measure to the Star Ratings in the future pending rulemaking. The measure was included in the 2023 MUC list for the PRMR process[40] to inform the selection of quality and efficiency measures for CMS programs. In the CY 2025 Advance Notice, we reiterated that we intend to propose to add the IOP-LD measure to the Star Ratings in future rulemaking.

Some commenters did not support adding this measure to the Star Ratings, while others supported the change. Several of the commenters were concerned about sufficient measure exclusions to reduce unintended consequences, alignment with guidelines or policies, or impacts to prescriber-patient decision making. A commenter suggested that risk adjustment may be needed; however, the IOP-LD measure is a process measure and process measures generally are not risk adjusted.[41] We will take the feedback we received into consideration as we consider adding this measure to the Star Ratings. Adding the IOP-LD measure to the Star Ratings must be proposed and adopted through rulemaking.

**Medication Adherence for Diabetes Medications/Medication Adherence for Hypertension (RAS Antagonists)/Medication Adherence for Cholesterol (Statins)/ Statin Use in Persons with Diabetes (SUPD)/ Medication Therapy Management (MTM) Program Completion Rate for CMR (Part D).** The Part D Star Ratings Medication Adherence, SUPD, and MTM measures currently exclude beneficiaries in hospice during the measurement year. Additionally, the Medication Adherence and SUPD measures exclude beneficiaries with an ESRD diagnosis or dialysis coverage dates during the measurement year. We proposed to change the data source used to identify beneficiaries who have elected to receive hospice care or with ESRD status (using ESRD dialysis coverage dates that overlap with the measurement year), as applicable to the measure specifications, from the Enrollment Database (EDB) to the Common Medicare Environment (CME) beginning with the 2024 measurement year.

Accessing this information through the CME will improve data availability for the monthly Patient Safety Reports for the Medication Adherence and SUPD measures. The CME database

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[39] Refer to CMS' Part D display page.
[40] Refer to the 2023 MUC list for the PRMR process.
[41] Refer to Developing and Testing Risk Adjustment Models for Social and Functional Status-Related Risk Within HealthCare Performance Measurement Final Technical Guidance – Phase 2 published December 21, 2022.

includes Medicare beneficiary enrollment and demographic data. Furthermore, the CME integrates different types of beneficiary data from CMS legacy systems; the CME database receives information from the EDB and contains additional information not available in the EDB.[42,43] CMS did not anticipate any impact on measure calculations due to this update. Based on our analysis, the CME and EDB data sources aligned very closely on measure exclusions. This would be a non-substantive update under § 423.184(d)(1)(v) because it only updates the data source.

Commenters supported updating the data source from the EDB to the CME to identify beneficiaries in hospice and/or with ESRD status, and some commenters requested more information on the impact to measure scores based on the change in data source. CMS recently migrated the beneficiary database, including the EDB and the CME data, to the Amazon Web Services (AWS Cloud). Equivalent EDB information to identify beneficiaries in hospice and with ESRD status is available in the CME beneficiary tables from the Integrated Data Repository (CME IDRC), sourced from the same upstream database. We tested the new process and obtained information from CMS' Office of Information Technology (OIT) to ensure an exact match. We have not observed negative impacts to measure calculations with this change but will continue to monitor. We will implement the data source change for the 2024 measurement year.

**Members Choosing to Leave the Plan (Part C & D).** A disenrollment as a result of a move out of a contract's service area is considered an involuntary disenrollment for this measure, meaning it is excluded from the measure numerator. If a member has a disenrollment reason code (DRC) 92, the member is not included in the numerator for this measure since this code captures moves out of the contract service area. In some cases, moves out of the service area are being recorded in the CMS systems using codes other than DRC 92, and disenrollees are then excluded from the numerator using contract service area data to identify where the new contract service area does not overlap with the old contract service area. Currently, we identify these enrollees by comparing the service area from the measurement year of the contract the enrollee is leaving ('old contract') to the service area from the measurement year and the following year of the contract into which the enrollee is enrolling ('new contract'). CMS plans to adjust the years of service area data used to identify beneficiaries leaving a contract due to a move out of the contract service area to better reflect contract service area at the time of the disenrollment. For disenrollments that occur at the end of the measurement year (December 31 of the measurement year), we will use the service area for the year following the measurement year for both the old

[42] Refer to CCW White Paper Master Beneficiary Summary File (MBSF): Impact of Enrollment Source Data Conversion From EDB to CME.
[43] Refer to SORN 09-70-0502.

and new contracts. For disenrollments that occur before December 31 of the measurement year, we will use the service area for the measurement year for the old and new contracts.

Applicable Integrated Plans, as defined at § 422.561, are D-SNPs with exclusively aligned enrollment with a Medicaid managed care organization. Because states may, using the contracts required by section 1859 of the Act and § 422.107, limit which MA organizations (and MA contracts) may offer a D-SNP (including a D-SNP that integrates Medicare and Medicaid coverage for the dually eligible enrollees), a beneficiary switching from an MA plan that is misaligned with their Medicaid managed care coverage to another MA plan that aligns Medicare and Medicaid plan enrollment is considered an involuntary disenrollment. CMS plans to exclude any enrollment into a plan designated as an Applicable Integrated Plan ("new contract") from the measure numerator for the contract the enrollee is leaving ("old contract"). There are two exceptions to this exclusion. If the plan in the old contract is also an Applicable Integrated Plan, then the enrollment is not excluded from the numerator. Also, any switch between D-SNPs in Florida is not excluded because all D-SNPs in Florida are directly capitated by the state for Medicaid services and therefore already provide aligned Medicare and Medicaid coverage.

The move out of the service area measure update is non-substantive as described at § 422.164(d)(1)(ii) because it does not meaningfully impact the numerator of the measure. Members that move out of a contract service area are already being removed from the numerator of this measure. This change to more accurately identify members moving out of the contract service area will only have a minor impact on the number of enrollees removed from the numerator. The update to exclude movement into an Applicable Integrated Plan is also non-substantive as it narrows the population covered by this measure as described at § 422.164(d)(1)(i).

All commenters that provided comments related to these updates were supportive. For the move out of service area update, a couple commenters asked if the DRC would change in these cases. No DRCs will be changed. Rather, CMS will use contract service area data as described above to exclude these disenrollments from the numerator of this measure. Annually around mid-July in an HPMS memo, CMS announces the availability of member level detail files for this measure for contracts to request. In these detail files, CMS provides information on whether a disenrollment met an exclusion criterion or was included in the numerator for the measure. These updates will be implemented beginning with the 2026 Star Ratings.

**Retirement of Star Ratings Measures**

**Care for Older Adults – Pain Assessment (Part C).** NCQA is retiring this indicator, which is part of the Care for Older Adults measure set, for the 2025 measurement year. The indicator is being retired for the following reasons: 1) pain assessments should be multidimensional, and the current indicator cannot ensure this, 2) the indicator does not differentiate between acute and

chronic pain, and 3) the indicator does not assess follow up care, and the evidence suggests that pain assessment alone does not improve quality of care. NCQA's plans for any new measures related to pain assessment are described in the Potential New Measure Concepts and Methodological Enhancements for Future Years section below.

CMS finalized in the April 12, 2023, final rule, "Medicare Program; Contract Year 2024 Policy and Technical Changes to the Medicare Advantage Program, Medicare Prescription Drug Benefit Program, Medicare Cost Plan Program, and Programs of All-Inclusive Care for the Elderly"[44] at § 422.164(e)(1)(iii) a new rule starting with the 2024 measurement year and 2026 Star Ratings that would allow CMS to remove a Star Ratings measure, without separate rulemaking, when a measure steward such as NCQA retires a measure. In the Advance Notice, CMS announced the removal of the Care for Older Adults – Pain Assessment measure in advance of the measurement period, as required by § 422.164(e)(2), based on NCQA's retirement of the measure. Most commenters supported the retirement of this measure, while a few commenters wanted the retirement to wait until a new measure was available. We shared these comments with NCQA; however, we note that NCQA has finalized the retirement of this measure for the 2025 measurement year. Thus, this measure will be removed from the program starting with the 2027 Star Ratings.

**Display Measures**

Display measures on CMS.gov are published separately from the Star Ratings and include measures that are transitioned from inclusion in the Star Ratings, new or updated measures before inclusion into the Star Ratings, and informational-only measures. Organizations and sponsors have the opportunity to preview the data for their display measures prior to release on CMS.gov. We anticipate all 2024 display measures will continue to be shown on CMS.gov in 2025 unless noted below.

**Follow-Up After Hospitalization for Mental Illness (Part C).** NCQA is reevaluating this measure for measurement year 2025 for continued relevance and alignment with the measure's intent, as well as its alignment with the larger suite of HEDIS behavioral health care continuity measures. NCQA is considering expanding both the measure's population and options for follow-up. Regarding the expansion of the measure's population, NCQA is reviewing additional mental health-related diagnosis codes for inclusion in the denominator (i.e., anxiety disorders, phobia disorders, and additional intentional self-harm codes). NCQA is also considering allowance of acute psychiatric events coded for intentional self-harm in any diagnosis position on the discharge claim (i.e., rather than the principal position only). Regarding the expansion of

[44] Refer to the Medicare Program; Contract Year 2024 Policy and Technical Changes to the Medicare Advantage Program, Medicare Prescription Drug Benefit Program, Medicare Cost Plan Program, and Programs of All-Inclusive Care for the Elderly Final Rule.

follow-up options, NCQA is exploring the possibility of allowing follow-up services by any care provider if coded for a mental health diagnosis in any position on the claim. NCQA also plans to assess the inclusion of additional types of services for follow-up (e.g., peer support services, occupational therapy for mental health). NCQA is in the process of testing the impact of these revisions and obtaining input from their advisory panels. Most commenters supported NCQA's work to update this measure, while a couple of commenters did not support expanding the denominator to include events with secondary diagnoses. We have shared the feedback we received on these potential updates with NCQA for their consideration.

**Social Need Screening and Intervention (Part C).** In the 2023 and 2024 Rate Announcements, we discussed the Social Need Screening and Intervention measure developed by NCQA as a potential future Star Ratings measure pending rulemaking. This measure is part of the Universal Foundation and our efforts to align measures across programs. Currently, a submission is underway to CMS' 2024 Pre-Rulemaking Measure Review process. We are adding this measure to the display page for the 2025 Star Ratings. NCQA also explored the addition of a utilities insecurity screening rate and intervention rate to the Social Need Screening and Intervention measure for measurement year 2026. The utilities insecurity screening rate would assess the percentage of members who had a screening for unmet utility needs. The intervention rate would assess the percentage of members who received a corresponding intervention within 30 days of screening positive for an unmet utility need. NCQA conducted qualitative feasibility testing with select health plans in 2023 to determine the ability to include this domain for reporting by Medicare health plans in the future. Testing revealed collecting utility insecurity data is possible, but challenges exist, specifically around data standardization and interoperability of data from multiple sources. Based on findings from testing and external stakeholder feedback, NCQA is pausing additional domain development until first year analysis of the current measure is completed in Summer 2024 to better inform the feasibility of adding domains. Some commenters were fully supportive of adding utility insecurity data to the Social Need Screening and Intervention measure, while others recommended further enhancements such as triple weighting this measure, including an interpersonal violence/safety domain, and improving the alignment between the use of Logical Observation Identifiers Names and Codes (LOINC), z-codes, and Current Procedural Terminology (CPT) codes. Other commenters raised concerns about the collection and reporting of social needs screening and intervention data due to burdens on providers, resource constraints, and the lack of standardized processes and tools. We have shared the feedback we received with NCQA for their consideration.

**Adult Immunization Status (Part C).** The Adult Immunization Status measure focuses on the percentage of members 19 years of age and older who are up to date on recommended routine vaccines for influenza; tetanus and diphtheria (Td) or tetanus, diphtheria, and acellular pertussis (Tdap); zoster; and pneumococcal. NCQA is planning to lower the denominator age from 66 to

65 years for measurement year 2025 for the pneumococcal indicator. When the pneumococcal indicator was initially developed, NCQA aligned it with ACIP guidelines in place at the time that recommended administration of multiple doses of the 13-valent pneumococcal conjugate vaccine (PCV13) and/or 23-valent pneumococcal polysaccharide vaccine (PPSV23) vaccine at least 12 months apart starting at age 65. Because of the need for at least two vaccines, NCQA set the lower age range in the denominator to 66 to allow time for those who may get their first dose at age 65 and their second dose after age 66. After ACIP updated their pneumococcal vaccine recommendations in 2023[45] to account for new vaccine types, NCQA updated the indicator for measurement year 2023 to align to these guidelines and assess receipt of at least one dose of any pneumococcal vaccine. Since the indicator only looks for one vaccine dose given the updated recommendations, NCQA is updating the lower age range for the denominator to age 65 years starting with the 2025 measurement year and 2027 Star Ratings display page.

NCQA is also planning to remove the option for receiving a herpes zoster live vaccination from the zoster indicator starting with measurement year 2025. The live zoster vaccine is no longer available for use in the United States, and ACIP recommends that adults who previously received the live zoster vaccine be re-vaccinated with the newer recombinant vaccine.

NCQA is also developing a new indicator for the Adult Immunization Status measure that would assess Hepatitis B vaccination for adults ages 19-59 for HEDIS measurement year 2025 based on updated recommendations from ACIP.[46]

Most commenters supported the proposed changes to the Adult Immunization Status measure, but support for the measure overall was mixed. Some commenters expressed concerns about patient refusals and accuracy and availability of vaccine data, while other commenters strongly supported this measure given the role vaccines play in preventative health. We have shared the feedback we received with NCQA for their consideration.

**Polypharmacy: Use of Anticholinergic Medications in Older Adults (Poly-ACH) (Part D).** The PQA updated the Poly-ACH measure specifications in the 2024 Measure Manual to align with the American Geriatric Society 2023 Updated Beers Criteria for Potentially Inappropriate Medication Use in Older Adults.[47] The updated Beers Criteria identified 14 medications for removal due to low usage or medication unavailability in the United States. The following medications identified for removal are: carbinoxamine, clemastine, dexchlorpheniramine, protriptyline, trimipramine, loxapine, thioridazine, trifluoperazine, disopyramide,

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[45] Refer to CDC's Pneumococcal Vaccine for Adults Aged ≥19 Years: Recommendations of the Advisory Committee on Immunization Practices, United States, 2023.

[46] Refer to CDC's Universal Hepatitis B Vaccination in Adults Aged 19–59 Years: Updated Recommendations of the Advisory Committee on Immunization Practices - United States, 2022.

[47] Refer to American Geriatrics Society 2023 updated AGS Beers Criteria® for potentially inappropriate medication use in older Adults.

methoscopolamine, dexbrompheniramine, pyrilamine, belladonna alkaloids, and propantheline. PQA defined low utilization as less than 4,000 United States Medicare beneficiaries 65 years or older receiving the medication in 2020 based on data from Medicare Part D Public Use Files. Less than 4,000 beneficiaries are approximately less than 0.01 percent of the Medicare population. CMS will align with the Beers Criteria and the PQA's updated measure specifications to remove the 14 medications from the Poly-ACH measure for the 2024 measurement year (2026 display page).

All commenters were supportive of this measure specification update to align with the Beers Criteria. These medications will be removed from the Poly-ACH measure for the 2024 measurement year (2026 display page).

**Polypharmacy: Use of Multiple CNS-Active Medications in Older Adults (Poly-CNS) / Poly-ACH (Part D).** Per the PQA's 2024 Measure Manual updates, the index prescription start date (IPSD) will be removed from the measure specifications for both Polypharmacy measures. The intent of the IPSD in the polypharmacy specifications, which required the earliest date of service for a target medication to occur 30 or more days from the last day of the measurement year, was to limit and define the eligible population for the Polypharmacy measures to beneficiaries who can potentially meet the numerator criteria. For example, if the first target prescription claim is not filled by early December, there are less than 30 days left in the measurement year to qualify for concurrent therapy use for the numerator.

To more precisely capture this concept, the PQA revised the measure specification to apply to instances of 2 or more prescription claims for the same target medication on different dates of service when determining if the earliest date of service for any target medication is 30 or more days from the last day of the measurement year. CMS will align with these PQA's measure clarifications for the 2024 measurement year (2026 display page) and does not anticipate these clarifications to impact the measure.

Commenters were supportive of this measure specification update to align with the PQA measure specifications. We will remove the IPSD from both Polypharmacy measures beginning with the 2024 measurement year (2026 display page).

**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).** The PQA is testing an update to exclude beneficiaries more broadly with cancer-related pain treatment from these opioid-related measures for measurement year 2025 at the earliest. The revised exclusion would align with the updated 2022 Centers for Disease Control and Prevention

(CDC) Clinical Practice Guideline for Prescribing Opioids for Pain.[48] We will also consider applying the updated measure specifications if implemented by the PQA.

Commenters were supportive of this potential measure specification revision to align with the updated 2022 CDC Guideline. Therefore, if the PQA updates the measure specifications for these opioid-related measures to exclude beneficiaries with cancer-related pain treatment, CMS will also implement the change for measurement year 2025 (2027 display page) at the earliest.

**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).** As referenced in the CY 2024 Rate Announcement,[49] CMS will align with the PQA measure specifications to use continuous enrollment (CE) and no longer adjust for member-years (MYs). We received support from commenters in response to the 2024 Advance Notice for this specification change to align with the PQA but noted that we would provide more information when the timeline for these measure changes is finalized. We will apply this change for the 2025 measurement year.

Commenters were supportive of CMS aligning with the PQA measure specifications by implementing CE and no longer adjusting for MYs. Commenters appreciated that CMS provided an anticipated timeline for transitioning the remainder of the Part D Patient Safety measures from MYs to CE. We plan to implement CE for these Part D Patient Safety measures in measurement year 2025 (2027 display page).

**Poly-CNS / Poly-ACH / COB / OHD / OMP (Part D)**. In the CY 2024 Rate Announcement, we announced that CMS will align with the PQA measure specifications to use CE for these display measures and no longer adjust for MYs for the 2024 measurement period. In the draft 2024 PQA Measure Manual, which the PQA shared with CMS noting anticipated changes to measures, the PQA noted the removal of the anchor date specifications from these measures, pending approval through the PQA's consensus-based measure maintenance process. Previously, the anchor date required an individual to be enrolled and to have a benefit on a specific date. Additionally, the allowable gap must not have included that date specified in the measure as the anchor date. The PQA's Measure Update Panel voted in support of removing the anchor date. When the CY 2025 Advance Notice was published, we anticipated that the PQA Quality Metrics Expert Panel (QMEP) would vote on the removal of the anchor date in early 2024 and stated that if the QMEP votes in support of removing the anchor date, effective measurement year 2024, then CMS would also not implement the anchor date to the applicable measures. Therefore,

[48] Refer to CDC Clinical Practice Guideline for Prescribing Opioids for Pain – United States, 2022.
[49] Refer to CMS' CY 2024 Rate Announcement.

when CMS implements the CE methodology for these measures beginning with the 2024 measurement year, the anchor date specification would be removed.

Subsequent to the release of the CY 2025 Advance Notice, the PQA QMEP voted in support to remove the anchor date from these measures, effective for measurement year 2024 and included the change in the 2024 PQA Measure Manual. We received very few comments on this measure specification update; however, the comments we received were supportive of the removal of the anchor date. CMS will remove the anchor date when we implement the CE methodology for these measures beginning with the 2024 measurement year (2026 display page).

**OHD/ OMP/Persistence to Basal Insulin (PST-INS)/ADH-ARV/COB/IOP-LD/Poly-CNS/Poly-ACH (Part D).** As mentioned earlier in connection with the Star Ratings Medication Adherence, SUPD, and MTM measures, we also proposed to remove the EDB as a data source for these display measures to identify beneficiaries who have elected to receive hospice care and/or with ESRD status (if applicable to the measure specifications) and instead use the CME beginning with the 2024 measurement year.

Commenters were supportive of updating the data source from the EDB to the CME to identify beneficiaries in hospice and/or with ESRD status. We will implement this change for the 2024 measurement year.

**Retirement of Display Measures**

**Antidepressant Medication Management (Part C).** NCQA will be retiring this measure starting with the 2024 measurement year because it only addresses one aspect of depression treatment (adherence to antidepressants), and other HEDIS depression measures more comprehensively assess monitoring and outcomes for individuals with depression. Consequently, CMS will be removing this measure from the 2026 display page. As announced in the 2024 Rate Announcement, we will be adding the Depression Screening and Follow-Up for Adolescents and Adults measure to the 2026 display page. All commenters supported the removal of the Antidepressant Medication Management measure from the 2026 display page.

**Use of Opioids from Multiple Providers in Persons Without Cancer (OMP) (Part D).** The PQA may retire the OMP measure due to the very low measure rates, resulting in minimal opportunity for measure improvement. Additionally, due to the narrow range of the measure rates, the measure does not effectively discern good versus poor performance. The PQA Measure Update Panel and QMEP voted in favor of retirement consideration. If the PQA membership votes in favor of retirement in 2024, CMS will retire the OMP measure from the 2027 display page (2025 measurement year). We anticipate that the PQA membership vote will occur sometime in 2024.

All commenters were supportive of retiring the OMP measure from the display page. Therefore, if the PQA membership votes in favor of retiring the OMP measure in 2024, CMS will also retire the OMP measure from the 2025 measurement year (2027 display page) to align with the PQA, the measure steward of the OMP measure.

**Potential New Measure Concepts and Methodological Enhancements for Future Years**

CMS' process for adding any new measures to the Star Ratings system includes developing and testing new measures, soliciting feedback on potential new measures, submitting the measures for approval under the PRMR process, and undertaking notice and comment rulemaking to propose and finalize new measures. CMS solicited comments on new measure concepts and methodological changes to inform future changes to the Star Ratings, as described in §§ 422.164(c) and 423.184(c).

**Health Outcomes Survey (Part C).** CMS continues to explore ways to enhance and refine existing Health Outcomes Survey (HOS) measures, develop new and methodologically simpler cross-sectional and longitudinal measures, expand measurement of physical functioning and mental health, and measure and address health equity. CMS is currently seeking OMB approval to conduct a field test to evaluate the measurement properties of potential new survey items, the effects of revised survey content, and the addition of a web-based survey mode to the existing mixed mode protocol (mail with telephone follow up for mail non-respondents). The results from the field test will be used to inform decisions on potential changes to HOS content, as well as survey administration procedures. Potential new measures derived from new HOS items will go through the PRMR process before potentially being proposed through future rulemaking for addition to the Star Ratings.

The new survey content to be tested includes the following three key items:

(1) Patient-Reported Outcomes Measurement Information System (PROMIS) Physical Function Items: The survey questions, taken from the PROMIS Physical Function and Mobility v2.0 item banks,[50,51] evaluate a wider range of functional impairment among MA enrollees than existing HOS items and may potentially enhance the Physical Functioning Activities of Daily Living (PFADL) measure.

(2) Generalized Anxiety Disorder 2 (GAD-2) Items: The GAD-2 scale[52] measures

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[50] HealthMeasures, "Search & View Measures." Accessed on March 10, 2023.

[51] Schalet, B.D., Hays, R.D., Jensen, S.E., Beaumont, J.L., Fries, J.F., & Cella, D. (2016). Validity of PROMIS® Physical Function Measures in Diverse Clinical Samples. Journal of Clinical Epidemiology, 73, 112-118.

[52] Wild, B., Eckl, A., Herzog, W., Niehoff, D., Lechner, S., Maatouk, I., ... & Löwe, B. (2014). Assessing generalized anxiety disorder in elderly people using the GAD-7 and GAD-2 scales: results of a validation study. The American journal of geriatric psychiatry, 22(10), 1029-1038.

anxiety, a significant mental health concern among both older adults[53] and MA enrollees with disabilities.[54] These anxiety measures offer a broader assessment of mental health than the existing HOS items that measure depression alone.

(3) Health-Related Social Needs (HRSN) Items: These survey questions were developed by CMS to assess ongoing unmet social needs related to social determinants of health, such as transportation availability, food insecurity, and housing instability. The questions differ from the CMS-approved screening questions for MA SNP health risk assessments that focus on identifying beneficiaries in need, in that the HOS questions are intended to assess whether plans are addressing beneficiary needs, and whether there are ongoing unmet needs. The proposed HOS items are focused on all MA enrollees, and whether the plan or provider's office asked enrollees about their needs, whether help was received if needed, and whether the enrollees have an ongoing unmet need. These questions underscore CMS' commitment to measuring and addressing the needs of people with Medicare and are intended to complement the new HEDIS Social Need Screening and Intervention (SNS-E) measure that assesses both screening for unmet food, housing, and transportation needs and referral to intervention for those who screen positive by providing additional data on ongoing unmet needs related to housing instability, food insecurity, and transportation availability in the MA population.

During the proposed field test, select existing HOS questions will be replaced with new content in the questionnaires. All questions removed in the field test were done so based on evidence and relevance. For example, several survey items were removed from the field test survey that do not have a significant impact on case-mix adjustment. These include whether the survey was completed by a proxy, type of cancer the respondent had, and whether the respondent lives alone. Testing of the new, revised, and existing HOS content will provide information needed to develop a shorter and more effective updated HOS instrument. Going forward, analysis of quantitative data collected from the field test will determine which questions will be recommended for future inclusion in the HOS.

Most commenters appreciated CMS' efforts to refine and update HOS, test the addition of web to the mixed-mode methodology for survey administration, and add new measures related to functional status, mental health, and health-related social needs. However, some commenters noted overlap and redundancy with other measures (e.g., PROMIS Physical Function and Functional Status Assessment Follow-up; GAD-2 and Depression Screening and Follow-Up; and

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[53] Koma, W., True, S., Fuglesten Biniek, J., Cubanski, J., Orgera, K., & Garfield, R. (2020). One in four older adults report anxiety or depression amid the COVID-19 pandemic. KFF-Medicare. Accessed on March 15, 2023.

[54] Friedman, C. (2022). The mental health of Medicare beneficiaries with disabilities during the COVID-19 pandemic. Rehabilitation Psychology, 67(1), 20.

HRSN and SNS-E) and questioned whether the HOS is the appropriate vehicle to capture such data. They cited the length of the survey, reliability concerns due to small sample sizes and low response rates, and a lack of actionable member-level data for timely follow up with members who are struggling. A few commenters requested CMS assess the impact of new questions and survey procedures and provide a comprehensive analysis for public review and input following the field test.

CMS acknowledges similarities between the PROMIS, GAD-2, and HRSN items being field tested and new measures under development that focus on screening and follow-up for ECDS reporting. However, the intent of the proposed HOS questions is to gather patient-reported information. For example, the proposed HRSN items are not intended to replace the annual Health Risk Assessments (HRAs) conducted by plans or the SNS-E measure. Rather, the HOS items are intended to complement the electronic reporting of the SNS-E measure that assesses screening for unmet food, housing, and transportation needs and intervention referral if needed, by providing additional patient-reported data on ongoing unmet needs in the MA population to measure overall plan performance in addressing enrollees' social needs.

HOS quality measures used for Part C and D Star Ratings are not designed to identify the needs of individual enrollees for follow-up, but rather to measure plan performance across contracts for accountability. The purpose of blind data is to support objective, comparable assessment of plan performance. Comprehensive quality improvement approaches go beyond using HOS data to address concerns in specific enrollees and instead use the information to devise approaches that improve health outcomes for all members. HOS data may point to issues that plans need to explore more carefully, but the results should not substitute for information plans should be collecting and monitoring for quality improvement. We encourage plans to use their aggregated Baseline results to identify contract-level priorities and their two-year Follow-Up results to track progress and improvement. Clinical data, including HRAs, are better used to screen for and address patient-level needs as part of an ongoing quality improvement process.

Finally, recent enhancements to the HOS intended to improve reliability include increasing the minimum denominator from 30 to 100 and changes in the case-mix methodology. Oversampling is available to plans that have sufficient enrollment. CMS remains committed to transparency and will share field test results when they are available.

**Blood Pressure Control for Patients with Hypertension (Part C).** NCQA is exploring the development of a new blood pressure control measure that utilizes the capabilities of digital quality measures and leverages standardized electronic clinical data. The current Controlling High Blood Pressure measure from HEDIS assesses the percentage of members 18-85 years of age with hypertension whose blood pressure was adequately controlled (<140/90 mmHg). NCQA tested this new measure which expands upon the current denominator method by

including members with at least one claims-based diagnosis and at least one dispensed anti-hypertensive medication. Additionally, NCQA tested a lower evidence-based blood pressure control threshold (<130/80 mmHg). The proposed new measure leverages structured electronic clinical data for assessing the last reading in the measurement period using two separate rates of control: <140/90 mmHg and <130/80 mmHg. The new measure concept is being proposed for HEDIS for measurement year 2025. If a new HEDIS measure is introduced, CMS would consider adding it to the Star Ratings as a replacement for the existing Controlling Blood Pressure measure pending rulemaking.

Commenters raised a number of potential challenges with the proposed new measure, including lowering the threshold which could increase fall risk, dehydration, and overprescribing of hypertensive medications. Other commenters were concerned that the last reading may be unreliable or an outlier reading. There was mixed support for electronic data collection, and some commenters recommend keeping the existing blood pressure thresholds or considering exclusions. We shared the feedback we received with NCQA for their consideration as they continue to explore this new measure.

**Breast Cancer Screening Follow-Up (Part C).** NCQA is developing two new measures for HEDIS measurement year 2025 that expand the current Breast Cancer Screening measure to assess documentation and follow-up of abnormal mammogram results: Document Breast Imaging Reporting and Data System (BI-RADS) Assessment After Mammogram and Follow-up After Abnormal Breast Cancer Assessment. These measures would use the HEDIS Electronic Clinical Data Systems (ECDS) reporting method. Field testing results indicated challenges for health plans in reporting the measures, including lack of mature electronic health record data feeds to access necessary clinical data and inconsistent capture of data in structured fields. Despite these challenges, NCQA panels highlighted the importance of the measures and suggested that including the measures in HEDIS and other programs would incentivize plans to capture and exchange data needed to report the measures and drive increased quality of care. Most commenters supported the development of a new measure to assess documentation and follow-up of abnormal mammogram results, but several commenters asked for additional information about the potential new measure. Some commenters expressed concern about ECDS reporting, the feasibility of accessing clinical data in electronic health records, and under coding. We have shared this feedback with NCQA as they continue to work on developing measures in this area.

**Social Connection Screening and Intervention (Part C).** NCQA explored development of a new measure for measurement year 2026 or beyond that would assess the percentage of members aged 65 and older who were screened, using prespecified instruments, at least once during the measurement year for social isolation, loneliness, or inadequate social support and received a corresponding intervention if they screened positive. The proposed measure would have two

indicators, one for social connection screening and one for social connection intervention. This measure would be reported using electronic clinical data, including data from electronic health records, registries, case management systems, and administrative claims. This measure was brought to NCQA's Committee on Performance Measurement (CPM) for consideration for public comment in January 2024. Although the CPM agreed this was an important concept, the measure was not approved for public comment due to concerns around lack of evidence-based interventions, feasibility of data, and provider burden. NCQA has paused measure development work related to the concept until first year analysis of the SNS-E is conducted in the summer of 2024. NCQA will explore alternative avenues to contribute to the research related to this concept. Commenters had mixed reaction to this measurement concept, with some commenters raising challenges related to lack of appropriate coding and monitoring mechanisms. We have shared this feedback with NCQA for their consideration.

**Chronic Pain Assessment and Follow-Up (Part C).** NCQA explored development of a new measure that would assess chronic pain and follow-up in Medicare members aged 65 and older. The measure would assess the percentage of members screened for pain, percentage of members who screened positive for pain who had a documented comprehensive assessment, and percentage of members with pain who had follow-up. This measure would be reported using electronic clinical data, including data from electronic health records, registries, case management systems, and administrative claims. Measure testing identified significant challenges, including lack of mature electronic health record data feeds to access the necessary clinical data; inconsistent capture of data in structured fields mapped to standard terminology; inconsistent use of standardized, validated screening and assessment tools; and lack of use of comprehensive assessment tools in clinical care. NCQA's Committee on Performance Measurement did not approve moving the measure forward at this time due to reporting feasibility concerns as well as concerns with the measure concept and potential unintended consequences. NCQA has paused further measure development work at this time and will continue to monitor guidelines, evidence, and data availability to inform any potential future measures of chronic pain assessment. Commenters expressed mixed reaction to this measurement concept, including raising challenges around encouraging overprescribing of opioids, issues with electronic data collection, and whether the measure should include all MA enrollees. We have shared this feedback with NCQA for their consideration.

**Tobacco Use Screening and Cessation Intervention and Lung Cancer Screening (Part C).** NCQA is exploring the development of two new measures related to tobacco use screening and lung cancer screening. One measure is looking to assess whether adolescents and adults received a screening for current tobacco use and were provided with cessation strategies if currently using tobacco. The second measure is looking to assess whether individuals who meet screening criteria received an annual screening for lung cancer. The measure will target adults aged 50-80

who are current or former smokers. Both measures under development are being developed for the ECDS reporting method. These new HEDIS measures would be available to use no earlier than measurement year 2026. CMS is considering proposing these measures as Star Ratings measures in the future through rulemaking. Most commenters supported these measurement concepts, with some commenters noting how critical it is to detect lung cancer early. Some commenters wanted more information about the potential measures, including how the denominator for the lung cancer screening measure would be identified and which patients would be excluded from both measures. Other commenters made various suggestions such as including vaping, considering how the cost of scans impact the measure, and listing the accepted cessation strategies as part of the measure specifications. We have shared this feedback with NCQA as they continue their measure development efforts.

**Functional Status Assessment Follow-Up (Part C).** NCQA is exploring the development of a new measure to assess follow-up after a Functional Status Assessment. The new measure would focus on the follow-up and be specified for ECDS reporting. Any potential new measure is currently planned for implementation in measurement year 2026 at the earliest. Most commenters supported this effort, but asked for additional information such as whether this measure would be targeted at a specific population such as SNPs or the general population. We have shared this feedback with NCQA as they continue their measure development efforts.

**Medicare Plan Finder Drug Pricing Measure (Part D).** We are considering a new measure to evaluate the accuracy of sponsors' pricing data displayed on the Medicare Plan Finder (MPF) tool. Beneficiaries depend on the display of accurate data on MPF to compare their plan options. CMS currently has an MPF Price Accuracy measure as a part of the Part C and D Star Ratings.[55] This measure is calculated by comparing the MPF price to the Prescription Drug Event (PDE) price and determining the magnitude and frequency of differences found when the PDE price exceeds the MPF price. Additionally, there is a display measure that follows similar methodology, but that measure flags cases when the MPF price exceeds the PDE price.

One limitation of the current measures is that only MPF and PDE data from January 1-September 30 of a plan year are evaluated. Every October 1st, the MPF tool shifts to support the Medicare Annual Enrollment Period (AEP) by highlighting sponsors' projected health and drug costs for the following plan year. (Costs for the current plan year are no longer updated; therefore, we cannot fairly compare PDEs filled after September 30th.) It is important for Medicare beneficiaries to have reliable price comparisons to base their plan selections on for the upcoming year.

[55] Refer to the Star Ratings Technical Notes.

We are concerned that some plans may be submitting artificially high or low prices to display on the MPF during AEP. Plans may be submitting MPF pricing data that are lower during AEP than prices during the plan year to encourage beneficiaries to sign up for their plan, or conversely, plans may be submitting MPF pricing data that is higher during AEP than prices during the plan year to discourage certain beneficiaries from signing up for the plan.

We are interested in developing a new measure that would assess whether Part D sponsors are engaging in these pricing tactics by evaluating whether plans are substantially increasing or decreasing the MPF prices for drugs following AEP. Once developed, and before the measurement period, we would announce in a future Advance Notice when we would add the measure to the display page along with more specific details on the specifications. Public reporting of this information would provide transparency and highlight any contract-level outliers. After monitoring contracts' performance on this measure for at least two years, we may consider proposing to add it to the Star Ratings through rulemaking as a companion measure to the current MPF Price Accuracy measure.

We sought initial comment on this general measure concept. CMS also solicited feedback on the following:

- During each biweekly MPF submission, a plan sponsor can submit different unit costs for a particular drug (specific to the contract/plan/segment/pharmacy/ pharmacy service type/days of supply combination[56]). How should CMS calculate a plan sponsor's MPF prices during AEP for the purpose of comparing to prices during the plan year? We have considered the following possibilities:
    - As an average of prices displayed from October through December
    - As a weighted average of prices displayed from October through December, with greater weight given to data displayed during MPF's higher web-traffic weeks
- When comparing a drug's price between AEP and the plan year, should pricing data be aggregated to a single price for a drug prior to comparison? As described previously, a plan sponsor can submit different MPF unit costs for a given drug at a retail pharmacy, versus a mail order pharmacy.
- Is it more important that AEP prices are stable (as in, relative to a sponsor's prices displayed on MPF during the plan year) or reliable (as in, compared to a sponsor's PDEs during the plan year)?
    - If the former - Should we compare a sponsor's MPF prices throughout the plan year as a rolling average, quarterly snapshot, or by each biweekly posting period?
    - If the latter – Should we compare sponsors' PDE data averaged across the plan year? Or alternatively, similar to how we currently calculate the MPF accuracy

[56] Refer to the 2024 Pricing Data Guidelines.

measure, we could assign an AEP MPF price to each PDE throughout the plan year and then calculate the magnitude and frequency of differences.

- To account for industry-wide price changes, could CMS:
    - Compare plans' price changes to changes in wholesale acquisition cost (WAC), average wholesale price (AWP), and/or average unit price changes across plan sponsors? For example, if a price difference was found between AEP and the plan year, should the difference only be counted if it exceeds the change in WAC over the same time period?
    - Utilize a methodology to identify outlier contracts, instead of defining allowed thresholds for price changes?
- Should CMS calculate plan price changes using percent or a dollar value? CMS currently calculates the MPF accuracy measure using a two cent ($0.02) threshold.[57]
- Should CMS continue to separately evaluate MPF price increases and decreases, like the current MPF Price Accuracy measures used for Star Rating and display measures?

Additionally, we recognize that this new measure concept is similar to the MPF - Stability display measure, which evaluates the stability in a plan's point of sale prices by comparing quarter to quarter PDE prices. We hope in the future to measure price stability in the MPF tool in a more nuanced way. As we work to refine the new measure concept, we plan on retiring the MPF - Stability display measure.

CMS received mixed support from commenters on the general measure concept. Supporters agreed that it is important for Medicare beneficiaries to have accurate data on MPF to compare their plan options for the upcoming year and for CMS to identify plans displaying inaccurate pricing during AEP. Those opposed cited market fluctuations may result in volatility of some drug prices outside of plan control or expressed concerns that the current MPF Price Accuracy measure specifications would also negatively impact this proposed measure. Some commenters suggested that this type of plan behavior would be best addressed through CMS audits and compliance actions. Several commenters provided information on the specific questions posed. We appreciate the comments we received as we consider future development of MPF pricing data analyses and performance measures. CMS would provide additional information and more detailed specifications to support any proposal for a new display measure in a future Advance Notice. A measure would go through the PRMR process before potentially being proposed through future rulemaking for addition to the Star Ratings.

[57] Refer to the Star Ratings Technical Notes.

## Attachment VII. Economic Information for the CY 2025 Rate Announcement

Below, we provide the economic information for significant provisions in the Rate Announcement. Provisions not specifically addressed below are intended to represent a continuation of the policies established for CY 2024 and, as a result, do not have an impact associated with them.

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

#### *A1. Medicare Advantage and PACE non-ESRD Ratebook*

The FFS growth percentage for the 2025 MA non-ESRD rates is estimated to be 2.33 percent, and the MA growth percentage for the 2025 MA non-ESRD rates is estimated to be 2.31 percent. The MA non-ESRD ratebook impact summarized here is calculated by comparing 2025 Part C expenditures reflecting these growth rate assumptions to the expected 2025 Part C expenditures assuming the MA non-ESRD ratebook remains unchanged from that finalized for 2024. The net impact on the Medicare Trust Funds for CY 2025 is expected to be $8.8 billion. This figure accounts for the impact of the benchmark rate cap, MA rebate, and MA EGWP policies, as well as the portion of the difference between benchmarks and bids that the government retains, and the portion of the program costs covered by Part B premiums.

The MA growth percentage, used to calculate the 2025 PACE non-ESRD rates as well as in development of the applicable amount used in setting MA non-ESRD rates, is estimated to be 2.31 percent. The PACE non-ESRD ratebook impact is calculated by comparing the 2025 PACE expenditures reflecting this growth rate assumption to the expected 2025 PACE expenditures assuming that the PACE non-ESRD ratebook remains unchanged from the CY 2024 PACE non-ESRD ratebook. The net impact on the Medicare Trust Funds for CY 2025 for the PACE ratebook change is expected to be $60 million. This figure accounts for the portion of the program costs covered by Part B premiums.

The net impact on the Medicare Trust Funds for CY 2025 of implementing the zero-claims adjustment in Puerto Rico is expected to be $260 million.

#### *A2. Medicare Advantage and PACE ESRD Ratebooks*

The FFS growth percentage for the 2025 MA ESRD rates is estimated to be 1.76 percent. The impact on the MA and PACE ESRD ratebooks is calculated by comparing projected 2025 Part C expenditures with this growth rate assumption to the expected 2025 Part C expenditures with the assumption that the MA and PACE ESRD ratebooks would have been unchanged from those finalized for 2024. The net impact on the Medicare Trust Funds for CY 2025 is expected to be

$550 million. This figure accounts for the portion of the program costs covered by Part B premiums.

### *A3. CMS-HCC Risk Adjustment Model*

For CY 2025 CMS is calculating risk scores for Non-PACE Part C organizations as a blend of 33 percent of the 2020 CMS-HCC risk adjustment model and 67 percent of the 2024 CMS-HCC model. The CY 2025 impact on MA risk scores of the blended Part C CMS-HCC models, relative to the blend in CY 2024, is projected to be -2.45 percent, which represents a $9.2 billion net savings to the Medicare Trust fund in 2025. The 2020 CMS-HCC model (2015 denominator) and the 2024 CMS-HCC model (2020 denominator) have different denominator years (i.e., number of years of risk score trend). Therefore, risk scores under the models are not comparable when determining impacts due to the different number of years of risk score trend. In order to isolate the impact of the model updates, the risk scores being compared were each appropriately normalized to remove the impact of FFS risk score trend. When estimating the impact of the proposed model, the impact takes into account the portion of the difference between benchmarks and bids that the government retains, and the portion of the program costs covered by Part B premiums.

### *A4. ESRD Risk Adjustment Model*

For CY 2025, CMS is continuing the use of the ESRD risk adjustment models implemented in CY 2024. Therefore, no economic impact is applicable.

### *A5. Frailty Adjustment for FIDE SNPs*

For CY 2025, CMS is calculating frailty scores for FIDE SNPs as a blend of 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, consistent with the blend that is being proposed for the Part C risk adjustment model. Additionally, CMS is using only the full Medicaid frailty factors to calculate FIDE SNP frailty scores for FIDE SNP enrollees to align with the requirement that FIDE SNPs must have exclusively aligned enrollment, meaning that enrollment in FIDE SNPs will be limited to full-benefit dually eligible individuals, beginning in 2025. The CY 2025 impact of transitioning to frailty scores calculated using the 33 percent/67 percent blend, and using full Medicaid frailty factors only, relative to CY 2024, is a change in frailty scores of 1.9 percent, which represents a net cost of less than $10 million dollars to the Medicare Trust Funds in 2025. This impact takes into account the portion of the difference between benchmarks and bids that the government retains, and the portion of the program costs covered by Part B premiums.

### *A6. MA Coding Pattern Difference Adjustment*

For CY 2025, we will continue to apply the statutory minimum coding pattern difference adjustment (5.90 percent). There is no change in policy from CY 2024, and we applied the same factor for CY 2024, therefore the year-over-year impact is zero.

### *A7. Part C Normalization*

The normalization factors serve to offset the trend in risk scores and maintain a 1.0 average FFS risk score for the CMS-HCC models. For CY 2025, for all CMS-HCC risk adjustment models, CMS is calculating the normalization factors using a five-year multiple linear regression methodology and average historical FFS risk scores from 2019 through 2023. Since normalization is applied to risk scores to maintain the same average risk score year-over-year, 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*

The methodology for updating other Part D parameters for CY 2025 generally remains unchanged from that used for CY 2024. However, statutory changes, including the lowering of the annual OOP threshold to $2,000 and the change in the benefit structure from four phases to three phases, may result in potential payment impacts for CY 2025. At this time, the impact on the Medicare Trust Fund is uncertain since the impact of such parameter updates is generally dependent on the behavior and bid assumptions of Part D plan sponsors.

### *B2. Part D Risk Adjustment Model*

For CY 2025, we are proposing to implement an updated version of the RxHCC risk adjustment model. We focused on updating the model to reflect the statutory changes in the Part D benefit structure for CY 2025. As described in Attachment V, CMS is finalizing 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. In order to calculate risk scores for payment, the dollar coefficients must be denominated to create relative factors. The denominator is the average predicted per capita expenditure predicted by the payment model for a given year. To calculate the denominator, we use the recalibrated model and diagnosis data for Medicare beneficiaries enrolled in both MA-PDs and PDPs, which results in an average risk score for the enrolled Part D population in the denominator year of 1.0. Recalibration of the RxHCC model can result in changes in risk scores for individual beneficiaries and for plan level risk scores; however, the average risk score in the denominator year remains a 1.0, and the application of the normalization factor functions to maintain the 1.0 in the payment year. Since

the average risk score is 1.0 under the existing model and the recalibrated model, the economic impact of the recalibrated model is zero.

### *B3. Part D Normalization*

The normalization factors serve 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 calculating separate normalization factors for MA-PD plans and PDPs using the long-standing 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. Since normalization is applied to risk scores to maintain the same average risk score year-over-year, the impact of normalization is zero.

## Attachment VIII. RxHCC Risk Adjustment Factors and Predictive Ratio Tables

### Table VIII-1. 2025 RxHCC Model Relative Factors for Continuing Enrollees (2021/2022 calibration, HCPCS-based filtering logic)

| Variable | Description Label | Community, Non-Low Income, Age≥65 | Community, Non-Low Income, Age<65 | Community, Low Income, Age≥65 | Community, Low Income, Age<65 | Institutional |
|---|---|---|---|---|---|---|
| **Female** | | | | | | |
| 0-34 Years | | - | 0.260 | - | 0.625 | 2.503 |
| 35-44 Years | | - | 0.333 | - | 0.776 | 1.889 |
| 45-54 Years | | - | 0.335 | - | 0.729 | 1.554 |
| 55-59 Years | | - | 0.226 | - | 0.503 | 1.435 |
| 60-64 Years | | - | 0.168 | - | 0.308 | 1.059 |
| 65-69 Years | | 0.098 | - | 0.338 | - | 1.177 |
| 70-74 Years | | 0.078 | - | 0.048 | - | 0.926 |
| 75-79 Years | | 0.011 | - | 0.048 | - | 0.654 |
| 80-84 Years | | 0.011 | - | 0.048 | - | 0.426 |
| 85-89 Years | | 0.011 | - | 0.048 | - | 0.255 |
| 90-94 Years | | 0.011 | - | 0.048 | - | 0.069 |
| 95 Years or Over | | 0.011 | - | 0.048 | - | 0.069 |
| **Male** | | | | | | |
| 0-34 Years | | - | 0.221 | - | 0.673 | 2.137 |
| 35-44 Years | | - | 0.238 | - | 0.656 | 1.799 |
| 45-54 Years | | - | 0.225 | - | 0.548 | 1.432 |
| 55-59 Years | | - | 0.218 | - | 0.447 | 1.133 |
| 60-64 Years | | - | 0.223 | - | 0.318 | 0.892 |
| 65-69 Years | | 0.175 | - | 0.334 | - | 0.916 |
| 70-74 Years | | 0.144 | - | 0.249 | - | 0.716 |
| 75-79 Years | | 0.119 | - | 0.165 | - | 0.495 |
| 80-84 Years | | 0.012 | - | 0.056 | - | 0.373 |
| 85-89 Years | | 0.012 | - | 0.056 | - | 0.228 |
| 90-94 Years | | 0.012 | - | 0.056 | - | 0.089 |
| 95 Years or Over | | 0.012 | - | 0.056 | - | 0.005 |
| **Originally Disabled Interactions with Sex** | | | | | | |
| Originally Disabled Female | | 0.021 | - | 0.282 | - | 0.265 |
| Originally Disabled Male | | - | - | 0.165 | - | 0.265 |
| **Disease Coefficients** | | | | | | |
| RXHCC1 | HIV/AIDS | 7.940 | 9.314 | 8.449 | 8.505 | 5.905 |
| RXHCC5 | Opportunistic Infections | 0.436 | 0.463 | 0.548 | 0.231 | 0.246 |
| RXHCC15 | Chronic Myeloid Leukemia | 4.702 | 3.945 | 13.318 | 19.171 | 8.852 |

| Variable | Description Label | Community, Non-Low Income, Age≥65 | Community, Non-Low Income, Age<65 | Community, Low Income, Age≥65 | Community, Low Income, Age<65 | Institutional |
|---|---|---|---|---|---|---|
| RXHCC16 | Multiple Myeloma and Other Hematologic Cancers | 12.844 | 12.971 | 11.996 | 11.592 | 4.719 |
| RXHCC17 | Secondary Cancer of Bone and Kidney | 4.702 | 3.945 | 10.176 | 9.240 | 4.151 |
| RXHCC18 | Secondary Cancer of Lung, Liver, Brain, and Other Sites | 2.623 | 2.196 | 3.764 | 3.346 | 1.098 |
| RXHCC19 | Leukemias and Other Hematologic Cancers | 2.623 | 2.196 | 3.764 | 3.346 | 1.098 |
| RXHCC20 | Lung, Kidney, and Other Cancers; Secondary Cancer of Lymph Nodes and Other Sites | 0.517 | 0.431 | 1.108 | 0.796 | 0.337 |
| RXHCC21 | Lymphomas and Other Hematologic Cancers | 0.412 | 0.091 | 0.454 | 0.304 | 0.137 |
| RXHCC22 | Prostate, Breast, Bladder, and Other Cancers and Tumors | 0.112 | 0.079 | 0.350 | 0.304 | 0.137 |
| RXHCC30 | Diabetes with Complications | 0.586 | 0.674 | 1.111 | 1.655 | 0.837 |
| RXHCC31 | Diabetes without Complication | 0.247 | 0.276 | 0.493 | 0.673 | 0.378 |
| RXHCC40 | Alpha-1-Antitrypsin Deficiency | 2.709 | 6.949 | 6.836 | 9.245 | 1.604 |
| RXHCC41 | Lysosomal Storage Disorders | 4.566 | 13.205 | 5.618 | 19.652 | 0.171 |
| RXHCC42 | Acromegaly and Other Endocrine and Metabolic Disorders | 1.710 | 4.262 | 2.300 | 4.484 | 1.008 |
| RXHCC43 | Pituitary, Adrenal Gland, and Other Endocrine and Metabolic Disorders | 0.008 | 0.056 | - | 0.019 | - |
| RXHCC44 | Thyroid Disorders | 0.061 | 0.127 | 0.135 | 0.299 | 0.145 |
| RXHCC47 | Disorders of Lipoid Metabolism | - | - | 0.037 | 0.102 | 0.027 |
| RXHCC54 | Chronic Viral Hepatitis C | 0.225 | 0.323 | 0.267 | 0.111 | 0.467 |
| RXHCC55 | Acute or Unspecified Viral Hepatitis C | 0.225 | 0.323 | 0.267 | 0.111 | 0.467 |
| RXHCC56 | Chronic Viral Hepatitis B and Other Specified Chronic Viral Hepatitis | 0.282 | 0.532 | 1.185 | 0.727 | 0.292 |
| RXHCC59 | Primary Biliary Cirrhosis | 0.929 | 1.063 | 1.143 | 1.724 | 1.201 |
| RXHCC65 | Chronic Pancreatitis | 0.358 | 0.568 | 0.695 | 0.993 | 0.737 |
| RXHCC66 | Pancreatic Disorders and Intestinal Malabsorption, Except Pancreatitis | 0.220 | 0.568 | 0.583 | 0.993 | 0.353 |
| RXHCC67 | Inflammatory Bowel Disease | 0.549 | 0.865 | 1.364 | 3.863 | 0.382 |
| RXHCC80 | Aseptic Necrosis of Bone | 0.134 | 0.184 | 0.181 | 0.273 | 0.203 |

| Variable | Description Label | Community, Non-Low Income, Age≥65 | Community, Non-Low Income, Age<65 | Community, Low Income, Age≥65 | Community, Low Income, Age<65 | Institutional |
|---|---|---|---|---|---|---|
| RXHCC81 | Psoriatic Arthropathy | 0.809 | 0.601 | 6.162 | 9.014 | 3.214 |
| RXHCC82 | Systemic Sclerosis | 0.759 | 0.895 | 1.426 | 2.345 | 0.522 |
| RXHCC83 | Rheumatoid Arthritis and Other Inflammatory Polyarthropathy | 0.205 | 0.229 | 1.394 | 2.345 | 0.522 |
| RXHCC84 | Systemic Lupus Erythematosus and Other Systemic Connective Tissue Disorders | 0.087 | 0.115 | 0.279 | 0.364 | 0.102 |
| RXHCC87 | Osteoporosis, Vertebral and Pathological Fractures | 0.044 | 0.197 | 0.213 | 0.404 | - |
| RXHCC95 | Sickle Cell Anemia | - | - | - | 1.586 | - |
| RXHCC96 | Acquired Hemolytic, Aplastic, and Sideroblastic Anemias | 0.775 | - | 0.769 | 0.792 | 0.050 |
| RXHCC98 | Hereditary Angioedema and Other Defects in the Complement System | 10.759 | 57.648 | 10.067 | 46.574 | 6.070 |
| RXHCC99 | Immune Disorders | 0.503 | 0.474 | 0.726 | 1.207 | 0.414 |
| RXHCC100 | Immune Thrombocytopenic Purpura | 0.334 | 0.245 | 1.749 | 2.108 | 1.517 |
| RXHCC111 | Alzheimer's Disease | - | - | - | - | - |
| RXHCC112 | Dementia, Except Alzheimer's Disease | - | - | - | - | - |
| RXHCC130 | Schizophrenia and Other Psychosis | 0.187 | 0.224 | 0.689 | 1.373 | 0.298 |
| RXHCC131 | Bipolar Disorders | 0.187 | 0.086 | 0.539 | 0.724 | 0.298 |
| RXHCC132 | Depression | 0.023 | - | 0.053 | 0.183 | 0.082 |
| RXHCC133 | Anxiety and Other Psychiatric Disorders | 0.005 | - | 0.012 | 0.086 | - |
| RXHCC146 | Profound or Severe Intellectual Disability/Developmental Disorder | 0.638 | 0.279 | 0.423 | 0.213 | - |
| RXHCC147 | Moderate Intellectual Disability/Developmental Disorder | 0.638 | - | 0.249 | 0.086 | - |
| RXHCC148 | Mild or Unspecified Intellectual Disability/Developmental Disorder | 0.638 | - | 0.112 | - | - |
| RXHCC153 | Myasthenia Gravis and Other Myoneural Disorders | 1.533 | 3.295 | 1.978 | 3.830 | 0.352 |
| RXHCC154 | Amyotrophic Lateral Sclerosis and Other Motor Neuron Disease | 1.054 | 1.757 | 0.933 | 2.172 | 0.214 |
| RXHCC155 | Spinal Cord Disorders | 0.037 | 0.163 | - | 0.143 | 0.074 |

| Variable | Description Label | Community, Non-Low Income, Age≥65 | Community, Non-Low Income, Age<65 | Community, Low Income, Age≥65 | Community, Low Income, Age<65 | Institutional |
|---|---|---|---|---|---|---|
| RXHCC157 | Chronic Inflammatory Demyelinating Polyneuritis | 4.327 | 8.466 | 5.878 | 8.531 | 0.832 |
| RXHCC158 | Inflammatory and Toxic Neuropathy | - | - | - | - | 0.030 |
| RXHCC159 | Multiple Sclerosis | 1.486 | 1.714 | 3.757 | 6.295 | 1.992 |
| RXHCC160 | Huntington Disease | 1.944 | 1.579 | 4.803 | 6.517 | 3.579 |
| RXHCC161 | Parkinson Disease | 0.434 | 0.748 | 0.514 | 0.898 | 0.582 |
| RXHCC163 | Intractable Epilepsy | 0.179 | 0.404 | 0.452 | 2.454 | 0.033 |
| RXHCC164 | Epilepsy and Other Seizure Disorders, Except Intractable Epilepsy | - | - | - | 0.069 | - |
| RXHCC166 | Migraine Headaches | 0.081 | 0.165 | 0.374 | 0.525 | 0.489 |
| RXHCC168 | Trigeminal and Postherpetic Neuralgia | 0.052 | 0.101 | 0.224 | 0.335 | 0.142 |
| RXHCC183 | Pulmonary Arterial Hypertension | 1.368 | 5.024 | 1.927 | 6.799 | 0.697 |
| RXHCC184 | Pulmonary Hypertension, Except Arterial, and Other Pulmonary Heart Disease | 0.210 | 0.334 | 0.273 | 0.453 | 0.302 |
| RXHCC186 | Heart Failure | 0.183 | 0.117 | 0.273 | 0.254 | 0.190 |
| RXHCC187 | Hypertension | 0.049 | 0.010 | 0.114 | 0.094 | 0.047 |
| RXHCC188 | Coronary Artery Disease | 0.064 | 0.029 | 0.198 | - | - |
| RXHCC191 | Ventricular Septal Defect and Major Congenital Heart Disorders | 0.125 | 0.517 | 0.128 | - | 0.271 |
| RXHCC193 | Atrial Arrhythmias | 0.511 | 0.187 | 0.518 | 0.204 | 0.448 |
| RXHCC207 | Spastic Hemiplegia | 0.161 | 0.037 | 0.064 | 0.173 | - |
| RXHCC215 | Venous Thromboembolism | 0.398 | 0.370 | 0.394 | 0.444 | 0.348 |
| RXHCC225 | Cystic Fibrosis | 8.025 | 29.472 | 4.007 | 38.624 | 4.455 |
| RXHCC226 | Idiopathic Pulmonary Fibrosis and Systemic Sclerosis with Lung Involvement | 4.538 | 3.168 | 5.695 | 4.279 | 1.441 |
| RXHCC227 | Pulmonary Fibrosis, Except Idiopathic | 0.336 | 0.426 | 0.418 | 0.837 | 0.344 |
| RXHCC228 | Severe Persistent Asthma | 0.897 | 0.669 | 2.554 | 2.824 | 1.216 |
| RXHCC229 | Chronic Obstructive Pulmonary Disease, Bronchiectasis, and Other Asthma | 0.186 | 0.097 | 0.371 | 0.280 | 0.344 |
| RXHCC243 | Glaucoma, Open-Angle or Moderate/Severe Stage | 0.147 | 0.256 | 0.396 | 0.498 | 0.277 |
| RXHCC244 | Other Non-Acute Glaucoma | 0.010 | 0.059 | 0.064 | - | 0.031 |
| RXHCC260 | Kidney Transplant Status | - | - | - | - | 0.132 |

| Variable | Description Label | Community, Non-Low Income, Age≥65 | Community, Non-Low Income, Age<65 | Community, Low Income, Age≥65 | Community, Low Income, Age<65 | Institutional |
|---|---|---|---|---|---|---|
| RXHCC261 | Dialysis Status, Including End Stage Renal Disease | - | - | - | - | - |
| RXHCC262 | Chronic Kidney Disease Stage 5 | - | - | - | - | - |
| RXHCC263 | Chronic Kidney Disease Stage 4 | - | - | - | - | - |
| RXHCC311 | Chronic Ulcer of Skin, Except Pressure | 0.137 | 0.113 | 0.106 | 0.128 | 0.026 |
| RXHCC314 | Pemphigus, Pemphigoid, and Other Bullous Skin Disorders | 0.261 | 0.288 | 0.534 | 1.568 | 0.329 |
| RXHCC316 | Psoriasis, Except with Arthropathy | 0.181 | 0.360 | 1.758 | 3.202 | 0.992 |
| RXHCC317 | Discoid Lupus Erythematosus | 0.043 | 0.115 | - | - | - |
| RXHCC355 | Narcolepsy and Cataplexy | 0.762 | 1.736 | 1.657 | 3.818 | 0.843 |
| RXHCC395 | Stem Cell, Including Bone Marrow, Transplant Status/Complications | 4.362 | 2.964 | 5.584 | 3.663 | 2.177 |
| RXHCC396 | Heart, Lung, Liver, Intestine, or Pancreas Transplant Status | - | - | - | - | 0.132 |
| **Non-Aged Disease Interactions** | | | | | | |
| NonAged_RXHCC1 | NonAged * HIV/AIDS | - | - | - | - | 1.313 |
| NonAged_RXHCC130 | NonAged * Schizophrenia and Other Psychosis | - | - | - | - | 0.828 |
| NonAged_RXHCC131 | NonAged * Bipolar Disorders | - | - | - | - | 0.744 |
| NonAged_RXHCC132 | NonAged * Depression | - | - | - | - | 0.394 |
| NonAged_RXHCC133 | NonAged * Anxiety and Other Psychiatric Disorders | - | - | - | - | 0.050 |
| NonAged_RXHCC159 | NonAged * Multiple Sclerosis | - | - | - | - | 2.518 |
| NonAged_RXHCC163 | NonAged * Intractable Epilepsy | - | - | - | - | 0.406 |

**NOTE**: The Part D Denominator used to calculate relative factors is $2,708.40. This Part D Denominator is based on the combined PDP and MA-PD populations.

**SOURCE**: RTI Analysis of 100% 2021-2022 Medicare Enrollment Data, 2022 Prescription Drug Event (PDE) Data, 2021 Professional Claims (Carrier), 2021 Inpatient Claims, 2021 Outpatient Claims, and 2021 Medicare Advantage Encounter Data.

## Table VIII-2. 2025 RxHCC Model Relative Factors for New Enrollees, Non-Low Income (2021/2022 calibration, HCPCS-based filtering logic)

| Variable | Not Concurrently ESRD, Not Originally Disabled | Concurrently ESRD, Not Originally Disabled | Not Concurrently ESRD, Originally Disabled | Concurrently ESRD, Originally Disabled |
|---|---|---|---|---|
| **Female** | | | | |
| 0-34 Years | 1.337 | 1.337 | - | - |
| 35-44 Years | 1.337 | 1.337 | - | - |
| 45-54 Years | 1.098 | 1.098 | - | - |
| 55-59 Years | 1.098 | 1.098 | - | - |
| 60-64 Years | 1.098 | 1.098 | - | - |
| 65 Years | 0.356 | 1.230 | 1.010 | 1.230 |
| 66 Years | 0.377 | 1.230 | 1.010 | 1.230 |
| 67 Years | 0.401 | 1.230 | 1.010 | 1.230 |
| 68 Years | 0.428 | 1.230 | 1.045 | 1.230 |
| 69 Years | 0.438 | 1.230 | 1.045 | 1.230 |
| 70-74 Years | 0.481 | 1.230 | 1.045 | 1.230 |
| 75-79 Years | 0.548 | 1.230 | 0.700 | 1.230 |
| 80-84 Years | 0.463 | 1.230 | 0.463 | 1.230 |
| 85-89 Years | 0.463 | 1.230 | 0.463 | 1.230 |
| 90-94 Years | 0.403 | 1.230 | 0.403 | 1.230 |
| 95 Years or Over | 0.403 | 1.230 | 0.403 | 1.230 |
| **Male** | | | | |
| 0-34 Years | 1.162 | 1.162 | - | - |
| 35-44 Years | 1.162 | 1.162 | - | - |
| 45-54 Years | 1.162 | 1.162 | - | - |
| 55-59 Years | 1.164 | 1.164 | - | - |
| 60-64 Years | 1.164 | 1.164 | - | - |
| 65 Years | 0.481 | 1.495 | 1.064 | 1.495 |
| 66 Years | 0.518 | 1.495 | 1.064 | 1.495 |
| 67 Years | 0.539 | 1.495 | 1.064 | 1.495 |
| 68 Years | 0.575 | 1.495 | 1.169 | 1.495 |
| 69 Years | 0.588 | 1.495 | 1.169 | 1.495 |
| 70-74 Years | 0.637 | 1.495 | 1.169 | 1.495 |
| 75-79 Years | 0.749 | 1.495 | 0.834 | 1.495 |
| 80-84 Years | 0.834 | 1.495 | 0.834 | 1.495 |
| 85-89 Years | 0.834 | 1.495 | 0.834 | 1.495 |
| 90-94 Years | 0.727 | 1.495 | 0.727 | 1.495 |
| 95 Years or Over | 0.727 | 1.495 | 0.727 | 1.495 |

**NOTES:**

1. The Part D Denominator used to calculate relative factors is $2,708.40. This Part D Denominator is based on the combined PDP and MA-PD populations.

2. Originally Disabled is defined as originally entitled to Medicare by disability only (OREC = 1).
3. For new enrollees, the concurrent ESRD marker is defined as at least one month in the payment year of ESRD status—dialysis, transplant, or functioning graft.

**SOURCE**: RTI Analysis of 100% 2021-2022 Medicare Enrollment Data, 2022 Prescription Drug Event (PDE) Data, 2021 Professional Claims (Carrier), 2021 Inpatient Claims, 2021 Outpatient Claims, and 2021 Medicare Advantage Encounter Data.

**Table VIII-3. 2025 RxHCC Model Relative Factors for New Enrollees, Low Income (2021/2022 calibration, HCPCS-based filtering logic)**

| Variable | Not Concurrently ESRD, Not Originally Disabled | Concurrently ESRD, Not Originally Disabled | Not Concurrently ESRD, Originally Disabled | Concurrently ESRD, Originally Disabled |
|---|---|---|---|---|
| **Female** | | | | |
| 0-34 Years | 1.929 | 2.050 | - | - |
| 35-44 Years | 2.710 | 2.710 | - | - |
| 45-54 Years | 2.710 | 2.710 | - | - |
| 55-59 Years | 2.285 | 2.364 | - | - |
| 60-64 Years | 2.141 | 2.141 | - | - |
| 65 Years | 1.189 | 2.059 | 1.815 | 2.059 |
| 66 Years | 0.862 | 2.059 | 1.128 | 2.059 |
| 67 Years | 0.783 | 2.059 | 1.058 | 2.059 |
| 68 Years | 0.774 | 2.059 | 1.058 | 2.059 |
| 69 Years | 0.774 | 2.059 | 1.058 | 2.059 |
| 70-74 Years | 0.774 | 2.059 | 1.058 | 2.059 |
| 75-79 Years | 0.774 | 2.059 | 0.966 | 2.059 |
| 80-84 Years | 0.736 | 2.059 | 0.736 | 2.059 |
| 85-89 Years | 0.736 | 2.059 | 0.736 | 2.059 |
| 90-94 Years | 0.412 | 2.059 | 0.412 | 2.059 |
| 95 Years or Over | 0.412 | 2.059 | 0.412 | 2.059 |
| **Male** | | | | |
| 0-34 Years | 1.485 | 2.396 | - | - |
| 35-44 Years | 2.090 | 2.090 | - | - |
| 45-54 Years | 2.090 | 2.090 | - | - |
| 55-59 Years | 1.953 | 2.086 | - | - |
| 60-64 Years | 1.817 | 2.008 | - | - |
| 65 Years | 1.140 | 2.008 | 1.614 | 2.008 |
| 66 Years | 0.833 | 2.008 | 1.161 | 2.008 |
| 67 Years | 0.811 | 2.008 | 1.029 | 2.008 |
| 68 Years | 0.744 | 2.008 | 0.766 | 2.008 |
| 69 Years | 0.720 | 2.008 | 0.720 | 2.008 |
| 70-74 Years | 0.720 | 2.008 | 0.720 | 2.008 |
| 75-79 Years | 0.643 | 2.008 | 0.643 | 2.008 |
| 80-84 Years | 0.643 | 2.008 | 0.643 | 2.008 |
| 85-89 Years | 0.558 | 2.008 | 0.558 | 2.008 |
| 90-94 Years | 0.441 | 2.008 | 0.441 | 2.008 |
| 95 Years or Over | 0.239 | 2.008 | 0.239 | 2.008 |

**NOTES:**

1. The Part D Denominator used to calculate relative factors is $2,708.40. This Part D Denominator is based on the combined PDP and MA-PD populations.
2. Originally Disabled is defined as originally entitled to Medicare by disability only (OREC = 1).

3. For new enrollees, the concurrent ESRD marker is defined as at least one month in the payment year of ESRD status—dialysis, transplant, or functioning graft.

**SOURCE**: RTI Analysis of 100% 2021-2022 Medicare Enrollment Data, 2022 Prescription Drug Event (PDE) Data, 2021 Professional Claims (Carrier), 2021 Inpatient Claims, 2021 Outpatient Claims, and 2021 Medicare Advantage Encounter Data.

**Table VIII-4. 2025 RxHCC Model Relative Factors for New Enrollees, Institutional (2021/2022 calibration, HCPCS-based filtering logic)**

| Variable | Not Concurrently ESRD | Concurrently ESRD |
|---|---|---|
| **Female** | | |
| 0-34 Years | 3.361 | 2.723 |
| 35-44 Years | 3.361 | 2.723 |
| 45-54 Years | 2.750 | 2.723 |
| 55-59 Years | 2.482 | 2.723 |
| 60-64 Years | 2.413 | 2.723 |
| 65 Years | 2.478 | 2.723 |
| 66 Years | 2.478 | 2.723 |
| 67 Years | 1.728 | 2.723 |
| 68 Years | 1.728 | 2.723 |
| 69 Years | 1.728 | 2.723 |
| 70-74 Years | 1.431 | 2.723 |
| 75-79 Years | 1.431 | 2.723 |
| 80-84 Years | 1.167 | 2.723 |
| 85-89 Years | 0.977 | 2.723 |
| 90-94 Years | 0.776 | 2.723 |
| 95 Years or Over | 0.424 | 2.723 |
| **Male** | | |
| 0-34 Years | 2.692 | 2.141 |
| 35-44 Years | 2.692 | 2.141 |
| 45-54 Years | 2.660 | 2.141 |
| 55-59 Years | 2.136 | 2.141 |
| 60-64 Years | 2.000 | 2.141 |
| 65 Years | 2.055 | 2.141 |
| 66 Years | 2.055 | 2.141 |
| 67 Years | 1.545 | 2.141 |
| 68 Years | 1.545 | 2.141 |
| 69 Years | 1.545 | 2.141 |
| 70-74 Years | 1.545 | 2.141 |
| 75-79 Years | 1.417 | 2.141 |
| 80-84 Years | 1.103 | 2.141 |
| 85-89 Years | 1.103 | 2.141 |
| 90-94 Years | 0.782 | 2.141 |
| 95 Years or Over | 0.782 | 2.141 |

**NOTES:**

1. The Part D Denominator used to calculate relative factors is $2,708.40. This Part D Denominator is based on the combined PDP and MA-PD populations.
2. For new enrollees, the concurrent ESRD marker is defined as at least one month in the payment year of ESRD status—dialysis, transplant, or functioning graft.

**SOURCE**: RTI Analysis of 100% 2021-2022 Medicare Enrollment Data, 2022 Prescription Drug Event (PDE) Data, 2021 Professional Claims (Carrier), 2021 Inpatient Claims, 2021 Outpatient Claims, and 2021 Medicare Advantage Encounter Data.

## Table VIII-5. 2025 RxHCC Model Relative Factors for Continuing Enrollees (2018/2019 calibration, specialty-based filtering logic)

| Variable | Description Label | Community, Non-Low Income, Age≥65 | Community, Non-Low Income, Age<65 | Community, Low Income, Age≥65 | Community, Low Income, Age<65 | Institutional |
|---|---|---|---|---|---|---|
| **Female** | | | | | | |
| 0-34 Years | | - | 0.193 | - | 0.455 | 2.183 |
| 35-44 Years | | - | 0.295 | - | 0.636 | 2.509 |
| 45-54 Years | | - | 0.333 | - | 0.647 | 1.904 |
| 55-59 Years | | - | 0.294 | - | 0.503 | 1.571 |
| 60-64 Years | | - | 0.230 | - | 0.306 | 1.316 |
| 65-69 Years | | 0.118 | - | 0.281 | - | 1.395 |
| 70-74 Years | | 0.110 | - | 0.034 | - | 1.073 |
| 75-79 Years | | 0.085 | - | 0.034 | - | 0.776 |
| 80-84 Years | | 0.008 | - | 0.034 | - | 0.535 |
| 85-89 Years | | 0.008 | - | 0.034 | - | 0.343 |
| 90-94 Years | | 0.008 | - | 0.034 | - | 0.178 |
| 95 Years or Over | | 0.008 | - | 0.034 | - | 0.010 |
| **Male** | | | | | | |
| 0-34 Years | | - | 0.160 | - | 0.545 | 2.284 |
| 35-44 Years | | - | 0.204 | - | 0.590 | 2.056 |
| 45-54 Years | | - | 0.262 | - | 0.531 | 1.766 |
| 55-59 Years | | - | 0.279 | - | 0.436 | 1.359 |
| 60-64 Years | | - | 0.271 | - | 0.323 | 1.056 |
| 65-69 Years | | 0.169 | - | 0.292 | - | 1.060 |
| 70-74 Years | | 0.146 | - | 0.213 | - | 0.772 |
| 75-79 Years | | 0.063 | - | 0.061 | - | 0.628 |
| 80-84 Years | | 0.063 | - | 0.061 | - | 0.448 |
| 85-89 Years | | 0.063 | - | 0.061 | - | 0.267 |
| 90-94 Years | | 0.063 | - | 0.061 | - | 0.100 |
| 95 Years or Over | | 0.063 | - | 0.061 | - | 0.100 |
| **Originally Disabled Interactions with Sex** | | | | | | |
| Originally Disabled Female | | 0.042 | - | 0.303 | - | 0.223 |
| Originally Disabled Male | | - | - | 0.174 | - | 0.223 |
| **Disease Coefficients** | | | | | | |
| RXHCC1 | HIV/AIDS | 7.892 | 9.639 | 8.371 | 8.825 | 5.550 |
| RXHCC5 | Opportunistic Infections | 0.364 | 0.490 | 0.547 | 0.426 | 0.450 |
| RXHCC15 | Chronic Myeloid Leukemia | 5.641 | 4.765 | 13.820 | 18.727 | 9.360 |
| RXHCC16 | Multiple Myeloma and Other Hematologic Cancers | 12.750 | 14.284 | 11.113 | 11.848 | 4.053 |
| RXHCC17 | Secondary Cancer of Bone and Kidney | 5.641 | 4.765 | 9.083 | 8.220 | 4.053 |
| RXHCC18 | Secondary Cancer of Lung, Liver, Brain, and Other Sites | 2.138 | 1.919 | 3.057 | 2.979 | 0.986 |
| RXHCC19 | Leukemias and Other Hematologic Cancers | 2.138 | 1.919 | 2.960 | 2.733 | 0.986 |
| RXHCC20 | Lung, Kidney, and Other Cancers; Secondary | 0.444 | 0.328 | 0.921 | 0.659 | 0.267 |

| Variable | Description Label | Community, Non-Low Income, Age≥65 | Community, Non-Low Income, Age<65 | Community, Low Income, Age≥65 | Community, Low Income, Age<65 | Institutional |
|---|---|---|---|---|---|---|
| | Cancer of Lymph Nodes and Other Sites | | | | | |
| RXHCC21 | Lymphomas and Other Hematologic Cancers | 0.323 | 0.114 | 0.308 | 0.229 | 0.118 |
| RXHCC22 | Prostate, Breast, Bladder, and Other Cancers and Tumors | 0.116 | 0.114 | 0.250 | 0.229 | 0.118 |
| RXHCC30 | Diabetes with Complications | 0.549 | 0.595 | 1.058 | 1.592 | 1.040 |
| RXHCC31 | Diabetes without Complication | 0.200 | 0.184 | 0.380 | 0.535 | 0.410 |
| RXHCC40 | Alpha-1-Antitrypsin Deficiency | 3.589 | 8.320 | 7.252 | 9.938 | 1.324 |
| RXHCC41 | Lysosomal Storage Disorders | 2.720 | 12.743 | 2.316 | 17.837 | 0.169 |
| RXHCC42 | Acromegaly and Other Endocrine and Metabolic Disorders | 1.801 | 3.471 | 2.459 | 5.541 | 0.650 |
| RXHCC43 | Pituitary, Adrenal Gland, and Other Endocrine and Metabolic Disorders | 0.041 | 0.125 | - | 0.075 | 0.040 |
| RXHCC44 | Thyroid Disorders | 0.068 | 0.152 | 0.145 | 0.275 | 0.134 |
| RXHCC47 | Disorders of Lipoid Metabolism | - | - | 0.044 | 0.131 | 0.071 |
| RXHCC54 | Chronic Viral Hepatitis C | 0.633 | 0.750 | 0.891 | 0.716 | 0.996 |
| RXHCC55 | Acute or Unspecified Viral Hepatitis C | 0.633 | 0.750 | 0.891 | 0.716 | 0.996 |
| RXHCC56 | Chronic Viral Hepatitis B and Other Specified Chronic Viral Hepatitis | 0.324 | 0.629 | 1.146 | 0.734 | 0.317 |
| RXHCC59 | Primary Biliary Cirrhosis | 0.987 | 1.317 | 1.226 | 1.888 | 1.226 |
| RXHCC65 | Chronic Pancreatitis | 0.314 | 0.574 | 0.532 | 0.840 | 0.529 |
| RXHCC66 | Pancreatic Disorders and Intestinal Malabsorption, Except Pancreatitis | 0.214 | 0.574 | 0.438 | 0.840 | 0.304 |
| RXHCC67 | Inflammatory Bowel Disease | 0.472 | 0.544 | 1.131 | 2.784 | 0.419 |
| RXHCC80 | Aseptic Necrosis of Bone | 0.184 | 0.170 | 0.133 | 0.247 | 0.133 |
| RXHCC81 | Psoriatic Arthropathy | 0.855 | 0.652 | 5.016 | 8.003 | 2.731 |
| RXHCC82 | Systemic Sclerosis | 0.871 | 0.535 | 1.634 | 2.090 | 0.479 |
| RXHCC83 | Rheumatoid Arthritis and Other Inflammatory Polyarthropathy | 0.242 | 0.304 | 1.224 | 2.090 | 0.479 |
| RXHCC84 | Systemic Lupus Erythematosus and Other Systemic Connective Tissue Disorders | 0.089 | 0.194 | 0.207 | 0.281 | 0.100 |
| RXHCC87 | Osteoporosis, Vertebral and Pathological Fractures | 0.050 | 0.180 | 0.203 | 0.381 | - |
| RXHCC95 | Sickle Cell Anemia | - | 0.541 | - | 1.613 | - |

| Variable | Description Label | Community, Non-Low Income, Age≥65 | Community, Non-Low Income, Age<65 | Community, Low Income, Age≥65 | Community, Low Income, Age<65 | Institutional |
|---|---|---|---|---|---|---|
| RXHCC96 | Acquired Hemolytic, Aplastic, and Sideroblastic Anemias | 0.694 | 0.497 | 0.732 | 0.874 | 0.196 |
| RXHCC98 | Hereditary Angioedema and Other Defects in the Complement System | 11.691 | 55.996 | 16.581 | 51.681 | 0.530 |
| RXHCC99 | Immune Disorders | 1.035 | 0.637 | 1.525 | 1.334 | 0.884 |
| RXHCC100 | Immune Thrombocytopenic Purpura | 0.293 | 0.152 | 1.350 | 1.524 | 0.849 |
| RXHCC111 | Alzheimer's Disease | - | - | - | - | - |
| RXHCC112 | Dementia, Except Alzheimer's Disease | - | - | - | - | - |
| RXHCC130 | Schizophrenia and Other Psychosis | 0.196 | 0.216 | 0.604 | 1.232 | 0.264 |
| RXHCC131 | Bipolar Disorders | 0.196 | 0.104 | 0.489 | 0.631 | 0.264 |
| RXHCC132 | Depression | 0.057 | 0.041 | 0.159 | 0.236 | 0.133 |
| RXHCC133 | Anxiety and Other Psychiatric Disorders | 0.027 | 0.041 | 0.059 | 0.152 | 0.052 |
| RXHCC146 | Profound or Severe Intellectual Disability/Developmental Disorder | 0.592 | 0.128 | 0.358 | 0.333 | - |
| RXHCC147 | Moderate Intellectual Disability/Developmental Disorder | 0.592 | - | 0.163 | 0.100 | - |
| RXHCC148 | Mild or Unspecified Intellectual Disability/Developmental Disorder | 0.592 | - | 0.034 | - | - |
| RXHCC153 | Myasthenia Gravis and Other Myoneural Disorders | 0.976 | 2.282 | 1.546 | 2.300 | 0.372 |
| RXHCC154 | Amyotrophic Lateral Sclerosis and Other Motor Neuron Disease | 0.716 | 1.381 | 0.385 | 1.519 | 0.089 |
| RXHCC155 | Spinal Cord Disorders | 0.065 | - | 0.034 | - | - |
| RXHCC157 | Chronic Inflammatory Demyelinating Polyneuritis | 3.651 | 6.556 | 5.215 | 7.679 | 1.784 |
| RXHCC158 | Inflammatory and Toxic Neuropathy | 0.058 | 0.119 | 0.009 | 0.190 | 0.145 |
| RXHCC159 | Multiple Sclerosis | 3.439 | 5.034 | 4.938 | 8.697 | 2.618 |
| RXHCC160 | Huntington Disease | 2.952 | 3.684 | 3.215 | 5.255 | 3.199 |
| RXHCC161 | Parkinson Disease | 0.484 | 0.762 | 0.500 | 0.731 | 0.471 |
| RXHCC163 | Intractable Epilepsy | 0.270 | 0.425 | 0.694 | 2.548 | 0.360 |
| RXHCC164 | Epilepsy and Other Seizure Disorders, Except Intractable Epilepsy | 0.049 | - | 0.017 | 0.138 | - |
| RXHCC166 | Migraine Headaches | 0.082 | 0.110 | 0.246 | 0.277 | 0.367 |
| RXHCC168 | Trigeminal and Postherpetic Neuralgia | 0.086 | 0.253 | 0.237 | 0.361 | 0.256 |

| Variable | Description Label | Community, Non-Low Income, Age≥65 | Community, Non-Low Income, Age<65 | Community, Low Income, Age≥65 | Community, Low Income, Age<65 | Institutional |
|---|---|---|---|---|---|---|
| RXHCC183 | Pulmonary Arterial Hypertension | 1.077 | 3.729 | 1.559 | 5.876 | 0.590 |
| RXHCC184 | Pulmonary Hypertension, Except Arterial, and Other Pulmonary Heart Disease | 0.170 | 0.302 | 0.211 | 0.377 | 0.242 |
| RXHCC186 | Heart Failure | 0.135 | 0.051 | 0.211 | 0.139 | 0.242 |
| RXHCC187 | Hypertension | 0.061 | 0.012 | 0.115 | 0.088 | 0.079 |
| RXHCC188 | Coronary Artery Disease | 0.052 | - | 0.181 | - | - |
| RXHCC191 | Ventricular Septal Defect and Major Congenital Heart Disorders | 0.139 | 0.655 | 0.439 | 0.308 | 0.206 |
| RXHCC193 | Atrial Arrhythmias | 0.400 | 0.110 | 0.352 | 0.116 | 0.290 |
| RXHCC207 | Spastic Hemiplegia | 0.158 | 0.113 | 0.152 | - | - |
| RXHCC215 | Venous Thromboembolism | 0.325 | 0.315 | 0.365 | 0.400 | 0.333 |
| RXHCC225 | Cystic Fibrosis | 3.607 | 19.938 | 2.053 | 24.025 | 1.088 |
| RXHCC226 | Idiopathic Pulmonary Fibrosis and Systemic Sclerosis with Lung Involvement | 4.486 | 3.371 | 4.577 | 3.764 | 1.354 |
| RXHCC227 | Pulmonary Fibrosis, Except Idiopathic | 0.347 | 0.462 | 0.469 | 1.126 | 0.388 |
| RXHCC228 | Severe Persistent Asthma | 0.783 | 0.556 | 1.758 | 1.730 | 1.228 |
| RXHCC229 | Chronic Obstructive Pulmonary Disease, Bronchiectasis, and Other Asthma | 0.208 | 0.087 | 0.449 | 0.355 | 0.388 |
| RXHCC243 | Glaucoma, Open-Angle or Moderate/Severe Stage | 0.186 | 0.219 | 0.417 | 0.498 | 0.367 |
| RXHCC244 | Other Non-Acute Glaucoma | 0.054 | - | 0.078 | - | 0.028 |
| RXHCC260 | Kidney Transplant Status | - | - | - | - | - |
| RXHCC261 | Dialysis Status, Including End Stage Renal Disease | - | - | - | - | - |
| RXHCC262 | Chronic Kidney Disease Stage 5 | - | - | - | - | - |
| RXHCC263 | Chronic Kidney Disease Stage 4 | - | - | - | - | - |
| RXHCC311 | Chronic Ulcer of Skin, Except Pressure | 0.164 | 0.142 | 0.191 | 0.313 | 0.068 |
| RXHCC314 | Pemphigus, Pemphigoid, and Other Bullous Skin Disorders | 0.316 | 1.015 | 0.474 | 0.980 | 0.303 |
| RXHCC316 | Psoriasis, Except with Arthropathy | 0.178 | 0.190 | 1.274 | 2.441 | 0.842 |
| RXHCC317 | Discoid Lupus Erythematosus | 0.077 | 0.157 | - | - | - |
| RXHCC355 | Narcolepsy and Cataplexy | 0.994 | 2.221 | 1.340 | 3.299 | 0.762 |
| RXHCC395 | Stem Cell, Including Bone Marrow, | 4.116 | 2.064 | 5.597 | 3.362 | 2.178 |

| Variable | Description Label | Community, Non-Low Income, Age≥65 | Community, Non-Low Income, Age<65 | Community, Low Income, Age≥65 | Community, Low Income, Age<65 | Institutional |
|---|---|---|---|---|---|---|
| | Transplant Status/Complications | | | | | |
| RXHCC396 | Heart, Lung, Liver, Intestine, or Pancreas Transplant Status | - | - | - | - | - |
| **Non-Aged Disease Interactions** | | | | | | |
| NonAged_RXHCC1 | NonAged * HIV/AIDS | - | - | - | - | 2.371 |
| NonAged_RXHCC130 | NonAged * Schizophrenia and Other Psychosis | - | - | - | - | 0.695 |
| NonAged_RXHCC131 | NonAged * Bipolar Disorders | - | - | - | - | 0.746 |
| NonAged_RXHCC132 | NonAged * Depression | - | - | - | - | 0.365 |
| NonAged_RXHCC133 | NonAged * Anxiety and Other Psychiatric Disorders | - | - | - | - | 0.022 |
| NonAged_RXHCC159 | NonAged * Multiple Sclerosis | - | - | - | - | 3.224 |
| NonAged_RXHCC163 | NonAged * Intractable Epilepsy | - | - | - | - | 0.651 |

**NOTE**: The Part D Denominator used to calculate relative factors is $2,282.44. This Part D Denominator is based on the combined PDP and MA-PD populations.

**SOURCE**: RTI Analysis of 100% 2018-2019 Medicare Enrollment Data, 2019 Prescription Drug Event (PDE) Data, 2018 Professional Claims (Carrier), 2018 Inpatient Claims, 2018 Outpatient Claims, and 2018 Medicare Advantage Encounter Data.

## Table VIII-6. 2025 RxHCC Model Relative Factors for New Enrollees, Non-Low Income (2018/2019 calibration, specialty-based filtering logic)

| Variable | Not Concurrently ESRD, Not Originally Disabled | Concurrently ESRD, Not Originally Disabled | Not Concurrently ESRD, Originally Disabled | Concurrently ESRD, Originally Disabled |
|---|---|---|---|---|
| **Female** | | | | |
| 0-34 Years | 0.969 | 0.969 | - | - |
| 35-44 Years | 1.217 | 1.217 | - | - |
| 45-54 Years | 1.217 | 1.217 | - | - |
| 55-59 Years | 1.217 | 1.217 | - | - |
| 60-64 Years | 1.217 | 1.217 | - | - |
| 65 Years | 0.383 | 1.228 | 1.072 | 1.228 |
| 66 Years | 0.413 | 1.228 | 1.072 | 1.228 |
| 67 Years | 0.425 | 1.228 | 1.072 | 1.228 |
| 68 Years | 0.447 | 1.228 | 1.072 | 1.228 |
| 69 Years | 0.479 | 1.228 | 1.072 | 1.228 |
| 70-74 Years | 0.505 | 1.228 | 1.034 | 1.228 |
| 75-79 Years | 0.575 | 1.228 | 0.779 | 1.228 |
| 80-84 Years | 0.564 | 1.228 | 0.564 | 1.228 |
| 85-89 Years | 0.564 | 1.228 | 0.564 | 1.228 |
| 90-94 Years | 0.442 | 1.228 | 0.442 | 1.228 |
| 95 Years or Over | 0.442 | 1.228 | 0.442 | 1.228 |
| **Male** | | | | |
| 0-34 Years | 1.145 | 1.145 | - | - |
| 35-44 Years | 1.145 | 1.145 | - | - |
| 45-54 Years | 1.145 | 1.145 | - | - |
| 55-59 Years | 1.155 | 1.155 | - | - |
| 60-64 Years | 1.155 | 1.155 | - | - |
| 65 Years | 0.488 | 1.518 | 1.003 | 1.518 |
| 66 Years | 0.515 | 1.518 | 0.986 | 1.518 |
| 67 Years | 0.543 | 1.518 | 0.986 | 1.518 |
| 68 Years | 0.554 | 1.518 | 0.967 | 1.518 |
| 69 Years | 0.554 | 1.518 | 0.967 | 1.518 |
| 70-74 Years | 0.635 | 1.518 | 0.967 | 1.518 |
| 75-79 Years | 0.719 | 1.518 | 0.719 | 1.518 |
| 80-84 Years | 0.719 | 1.518 | 0.719 | 1.518 |
| 85-89 Years | 0.719 | 1.518 | 0.719 | 1.518 |
| 90-94 Years | 0.399 | 1.518 | 0.399 | 1.518 |
| 95 Years or Over | 0.399 | 1.518 | 0.399 | 1.518 |

**NOTES:**

1. The Part D Denominator used to calculate relative factors is $2,282.44. This Part D Denominator is based on the combined PDP and MA-PD populations.
2. Originally Disabled is defined as originally entitled to Medicare by disability only (OREC = 1).
3. For new enrollees, the concurrent ESRD marker is defined as at least one month in the payment year of ESRD status—dialysis, transplant, or functioning graft.

**SOURCE**: RTI Analysis of 100% 2018-2019 Medicare Enrollment Data, 2019 Prescription Drug Event (PDE) Data, 2018 Professional Claims (Carrier), 2018 Inpatient Claims, 2018 Outpatient Claims, and 2018 Medicare Advantage Encounter Data.

## Table VIII-7. 2025 RxHCC Model Relative Factors for New Enrollees, Low Income (2018/2019 calibration, specialty-based filtering logic)

| Variable | Not Concurrently ESRD, Not Originally Disabled | Concurrently ESRD, Not Originally Disabled | Not Concurrently ESRD, Originally Disabled | Concurrently ESRD, Originally Disabled |
|---|---|---|---|---|
| **Female** | | | | |
| 0-34 Years | 1.620 | 1.898 | - | - |
| 35-44 Years | 2.395 | 2.395 | - | - |
| 45-54 Years | 2.395 | 2.395 | - | - |
| 55-59 Years | 2.007 | 2.251 | - | - |
| 60-64 Years | 1.934 | 2.063 | - | - |
| 65 Years | 1.114 | 2.020 | 1.625 | 2.020 |
| 66 Years | 0.804 | 2.020 | 1.091 | 2.020 |
| 67 Years | 0.748 | 2.020 | 1.091 | 2.020 |
| 68 Years | 0.748 | 2.020 | 1.091 | 2.020 |
| 69 Years | 0.748 | 2.020 | 0.975 | 2.020 |
| 70-74 Years | 0.748 | 2.020 | 0.894 | 2.020 |
| 75-79 Years | 0.707 | 2.020 | 0.707 | 2.020 |
| 80-84 Years | 0.707 | 2.020 | 0.707 | 2.020 |
| 85-89 Years | 0.707 | 2.020 | 0.707 | 2.020 |
| 90-94 Years | 0.443 | 2.020 | 0.443 | 2.020 |
| 95 Years or Over | 0.443 | 2.020 | 0.443 | 2.020 |
| **Male** | | | | |
| 0-34 Years | 1.373 | 1.927 | - | - |
| 35-44 Years | 1.957 | 1.957 | - | - |
| 45-54 Years | 1.957 | 1.957 | - | - |
| 55-59 Years | 1.770 | 1.957 | - | - |
| 60-64 Years | 1.627 | 2.013 | - | - |
| 65 Years | 1.117 | 2.124 | 1.419 | 2.124 |
| 66 Years | 0.787 | 2.124 | 0.907 | 2.124 |
| 67 Years | 0.735 | 2.124 | 0.893 | 2.124 |
| 68 Years | 0.735 | 2.124 | 0.893 | 2.124 |
| 69 Years | 0.655 | 2.124 | 0.655 | 2.124 |
| 70-74 Years | 0.655 | 2.124 | 0.655 | 2.124 |
| 75-79 Years | 0.647 | 2.124 | 0.647 | 2.124 |
| 80-84 Years | 0.647 | 2.124 | 0.647 | 2.124 |
| 85-89 Years | 0.647 | 2.124 | 0.647 | 2.124 |
| 90-94 Years | 0.349 | 2.124 | 0.349 | 2.124 |
| 95 Years or Over | 0.349 | 2.124 | 0.349 | 2.124 |

**NOTES:**

1. The Part D Denominator used to calculate relative factors is $2,282.44. This Part D Denominator is based on the combined PDP and MA-PD populations.
2. Originally Disabled is defined as originally entitled to Medicare by disability only (OREC = 1).
3. For new enrollees, the concurrent ESRD marker is defined as at least one month in the payment year of ESRD status—dialysis, transplant, or functioning graft.

**SOURCE**: RTI Analysis of 100% 2018-2019 Medicare Enrollment Data, 2019 Prescription Drug Event (PDE) Data, 2018 Professional Claims (Carrier), 2018 Inpatient Claims, 2018 Outpatient Claims, and 2018 Medicare Advantage Encounter Data.

## Table VIII-8. 2025 RxHCC Model Relative Factors for New Enrollees, Institutional (2018/2019 calibration, specialty-based filtering logic)

| Variable | Not Concurrently ESRD | Concurrently ESRD |
|---|---|---|
| **Female** | | |
| 0-34 Years | 3.742 | 2.625 |
| 35-44 Years | 3.580 | 2.625 |
| 45-54 Years | 3.501 | 2.625 |
| 55-59 Years | 2.870 | 2.625 |
| 60-64 Years | 2.838 | 2.625 |
| 65 Years | 2.721 | 2.625 |
| 66 Years | 2.721 | 2.625 |
| 67 Years | 2.721 | 2.625 |
| 68 Years | 1.755 | 2.625 |
| 69 Years | 1.755 | 2.625 |
| 70-74 Years | 1.617 | 2.625 |
| 75-79 Years | 1.617 | 2.625 |
| 80-84 Years | 1.269 | 2.625 |
| 85-89 Years | 0.948 | 2.625 |
| 90-94 Years | 0.741 | 2.625 |
| 95 Years or Over | 0.554 | 2.625 |
| **Male** | | |
| 0-34 Years | 3.304 | 2.521 |
| 35-44 Years | 2.931 | 2.521 |
| 45-54 Years | 2.813 | 2.521 |
| 55-59 Years | 2.718 | 2.521 |
| 60-64 Years | 2.280 | 2.521 |
| 65 Years | 2.366 | 2.521 |
| 66 Years | 2.366 | 2.521 |
| 67 Years | 1.764 | 2.521 |
| 68 Years | 1.764 | 2.521 |
| 69 Years | 1.764 | 2.521 |
| 70-74 Years | 1.764 | 2.521 |
| 75-79 Years | 1.578 | 2.521 |
| 80-84 Years | 1.158 | 2.521 |
| 85-89 Years | 0.968 | 2.521 |
| 90-94 Years | 0.968 | 2.521 |
| 95 Years or Over | 0.968 | 2.521 |

**NOTES:**

1. The Part D Denominator value used to calculate relative factors is $2,282.44. This Part D Denominator is based on the combined PDP and MA-PD populations.
2. For new enrollees, the concurrent ESRD marker is defined as at least one month in the payment year of ESRD status—dialysis, transplant, or functioning graft.

**SOURCE**: RTI Analysis of 100% 2018-2019 Medicare Enrollment Data, 2019 Prescription Drug Event (PDE) Data, 2018 Professional Claims (Carrier), 2018 Inpatient Claims, 2018 Outpatient Claims, and 2018 Medicare Advantage Encounter Data.

## Table VIII-9. 2025 RxHCC Model with Disease Hierarchies (previously published in the 2023 Rate Announcement[58])

| RxHCC | If the Disease Group is listed in this column… | …Then drop the RxHCC(s) listed in this column |
|---|---|---|
| | **RxHCC Model Hierarchical Condition Category Label** | |
| 15 | Chronic Myeloid Leukemia | 17, 18, 19, 20, 21, 22 |
| 16 | Multiple Myeloma and Other Hematologic Cancers | 17, 18, 19, 20, 21, 22 |
| 17 | Secondary Cancer of Bone and Kidney | 18, 19, 20, 21, 22 |
| 18 | Secondary Cancer of Lung, Liver, Brain, and Other Sites | 19, 20, 21, 22 |
| 19 | Leukemias and Other Hematologic Cancers | 20, 21, 22 |
| 20 | Lung, Kidney, and Other Cancers; Secondary Cancer of Lymph Nodes and Other Sites | 21, 22 |
| 21 | Lymphomas and Other Hematologic Cancers | 22 |
| 30 | Diabetes with Complications | 31 |
| 40 | Alpha-1-Antitrypsin Deficiency | 43 |
| 41 | Lysosomal Storage Disorders | 43 |
| 42 | Acromegaly and Other Endocrine and Metabolic Disorders | 43 |
| 54 | Chronic Viral Hepatitis C | 55 |
| 65 | Chronic Pancreatitis | 66 |
| 81 | Psoriatic Arthropathy | 83, 84, 316 |
| 82 | Systemic Sclerosis | 83, 84 |
| 83 | Rheumatoid Arthritis and Other Inflammatory Polyarthropathy | 84 |
| 84 | Systemic Lupus Erythematosus and Other Systemic Connective Tissue Disorders | 317 |
| 111 | Alzheimer's Disease | 112 |
| 130 | Schizophrenia and Other Psychosis | 131, 132, 133 |
| 131 | Bipolar Disorders | 132, 133 |
| 132 | Depression | 133 |
| 146 | Profound or Severe Intellectual Disability/Developmental Disorder | 147, 148 |
| 147 | Moderate Intellectual Disability/Developmental Disorder | 148 |
| 157 | Chronic Inflammatory Demyelinating Polyneuritis | 158 |
| 163 | Intractable Epilepsy | 164 |
| 183 | Pulmonary Arterial Hypertension | 184, 186, 187 |
| 184 | Pulmonary Hypertension, Except Arterial, and Other Pulmonary Heart Disease | 186, 187 |
| 186 | Heart Failure | 187 |
| 225 | Cystic Fibrosis | 229 |
| 226 | Idiopathic Pulmonary Fibrosis and Systemic Sclerosis with Lung Involvement | 227, 229 |
| 227 | Pulmonary Fibrosis, Except Idiopathic | 229 |
| 228 | Severe Persistent Asthma | 229 |
| 243 | Glaucoma, Open-Angle or Moderate/Severe Stage | 244 |
| 260 | Kidney Transplant Status | 261, 262, 263, 396 |
| 261 | Dialysis Status, Including End Stage Renal Disease | 262, 263 |
| 262 | Chronic Kidney Disease Stage 5 | 263 |

**NOTES:**

1. This table applies to all of the RxHCC models in the CY 2025 Rate Announcement.

**How Payments are Made with a Disease Hierarchy**:

[58] Refer to CMS' CY 2023 Rate Announcement.

**EXAMPLE:** If a beneficiary triggers RxHCCs 163 (Intractable Epilepsy) and 164 (Epilepsy and Other Seizure Disorders, Except Intractable Epilepsy), then RxHCC 164 will be dropped. In other words, payment will always be associated with the RxHCC in column 1 if an RxHCC in column 3 also occurs during the same collection period. Therefore, the organization's payment will be based on RxHCC 163 rather than RxHCC 164.

**SOURCE:** RTI International.

**Table VIII-10. 2025 RxHCC Model Predictive Ratios by Deciles of Predicted Risk (sorted low to high): Continuing Enrollee Model Segments, 2021/2022 calibration sample (HCPCS-filtered diagnoses)**

| Deciles | Community, Non-Low Income, Age≥65 | Community, Non-Low Income, Age<65 | Community, Low Income, Age≥65 | Community, Low Income, Age<65 | Institutional |
|---|---|---|---|---|---|
| Entire sample | 1.000 | 1.000 | 1.000 | 1.000 | 1.000 |
| First (lowest) decile | 0.569 | 1.217 | 0.662 | 1.102 | 0.690 |
| Second decile | 1.175 | 1.296 | 1.249 | 1.429 | 0.943 |
| Third decile | 1.513 | 0.976 | 1.172 | 1.194 | 1.014 |
| Fourth decile | 1.361 | 1.071 | 1.045 | 1.075 | 1.042 |
| Fifth decile | 1.047 | 0.977 | 1.020 | 1.029 | 1.049 |
| Sixth decile | 0.971 | 0.987 | 1.025 | 0.976 | 1.035 |
| Seventh decile | 0.978 | 0.996 | 0.996 | 0.975 | 1.025 |
| Eighth decile | 0.936 | 0.954 | 0.972 | 0.919 | 1.015 |
| Ninth decile | 0.955 | 0.995 | 0.962 | 0.969 | 0.995 |
| Tenth (highest) | 1.011 | 0.995 | 0.999 | 1.000 | 0.981 |
| Top 5% | 1.016 | 1.009 | 1.003 | 1.018 | 0.982 |
| Top 1% | 1.028 | 0.992 | 1.018 | 1.046 | 1.007 |
| Top 0.1% | 0.955 | 1.023 | 1.014 | 1.017 | 1.013 |

**Table VIII-11. 2025 RxHCC Model Predictive Ratios by Deciles of Predicted Risk (sorted low to high): New Enrollee Model Segments, 2021/2022 calibration sample (HCPCS-filtered diagnoses)**

| Deciles | Non-Low Income | Low Income | Institutional |
|---|---|---|---|
| Entire sample | 1.000 | 1.000 | 1.000 |
| First (lowest) decile | 0.928 | 1.002 | 0.998 |
| Second decile | 0.988 | 0.969 | 1.014 |
| Third decile | 1.043 | 1.030 | 1.025 |
| Fourth decile | 1.173 | 0.961 | 0.965 |
| Fifth decile | 0.963 | 1.008 | 0.996 |
| Sixth decile | 0.965 | 1.141 | 1.010 |
| Seventh decile | 1.037 | 0.995 | 0.999 |
| Eighth decile | 1.057 | 1.028 | 1.028 |
| Ninth decile | 1.001 | 0.963 | 0.979 |
| Tenth (highest) | 1.004 | 1.001 | 0.993 |
| Top 5% | 0.998 | 0.911 | 1.005 |
| Top 1% | 1.017 | 1.137 | 0.971 |
| Top 0.1% | 1.001 | 1.332 | 0.971 |

## Attachment IX. 2024 CMS-HCC Model Predictive Ratio Tables

### Table IX-1. Predictive Ratios by Deciles of Predicted Risk (sorted low to high): Non-Dual, Aged (Age >=65) Continuing Enrollee

| | 2014/2015 Sample | 2018/2019 Sample | | |
|---|---|---|---|---|
| **Deciles** | **2020 Model** | **2020 Model** | **2024 Model** | **Improvement in Predictive Risk** |
| Entire sample | 1.000 | 0.968 | 1.000 | - |
| First (lowest) decile | 0.968 | 0.902 | 0.977 |  |
| Second decile | 0.983 | 0.938 | 0.981 |  |
| Third decile | 0.996 | 0.940 | 1.026 |  |
| Fourth decile | 0.989 | 0.958 | 1.003 |  |
| Fifth decile | 1.003 | 0.977 | 0.995 |  |
| Sixth decile | 1.002 | 0.970 | 0.993 |  |
| Seventh decile | 1.005 | 0.983 | 0.996 |  |
| Eighth decile | 1.003 | 0.982 | 0.996 |  |
| Ninth decile | 1.003 | 0.987 | 1.006 |  |
| Tenth (highest) | 1.003 | 0.963 | 1.003 |  |
| Top 5% | 1.000 | 0.942 | 1.000 |  |
| Top 1% | 0.984 | 0.917 | 0.987 |  |
| Top 0.1% | 0.959 | 0.879 | 0.967 |  |

**Table IX-2. Predictive Ratios by Deciles of Predicted Risk (sorted low to high): Non-Dual, Disabled (Age <65) Continuing Enrollee**

| | 2014/2015 Sample | 2018/2019 Sample | | |
|---|---|---|---|---|
| **Deciles** | **2020 Model** | **2020 Model** | **2024 Model** | **Improvement in Predictive Risk** |
| Entire sample | 1.000 | 0.979 | 1.000 | - |
| First (lowest) decile | 1.090 | 1.100 | 0.932 | ↑ |
| Second decile | 0.959 | 0.975 | 0.990 | ↑ |
| Third decile | 0.982 | 0.964 | 0.983 | ↑ |
| Fourth decile | 0.982 | 0.977 | 1.011 | ↑ |
| Fifth decile | 0.952 | 0.968 | 0.955 | ↓ |
| Sixth decile | 0.997 | 0.965 | 0.997 | ↑ |
| Seventh decile | 0.983 | 0.972 | 0.997 | ↑ |
| Eighth decile | 1.008 | 1.004 | 1.002 | ↑ |
| Ninth decile | 1.028 | 1.013 | 1.022 | ↓ |
| Tenth (highest) | 1.001 | 0.959 | 1.004 | ↑ |
| Top 5% | 0.991 | 0.935 | 0.998 | ↑ |
| Top 1% | 0.999 | 0.922 | 0.981 | ↑ |
| Top 0.1% | 0.979 | 0.874 | 0.960 | ↑ |

**Table IX-3. Predictive Ratios by Deciles of Predicted Risk (sorted low to high): Full Benefit Dual, Aged (Age >=65) Continuing Enrollee**

| | 2014/2015 Sample | 2018/2019 Sample | | |
|---|---|---|---|---|
| **Deciles** | **2020 Model** | **2020 Model** | **2024 Model** | **Improvement in Predictive Risk** |
| Entire sample | 1.000 | 1.002 | 1.000 | - |
| First (lowest) decile | 0.969 | 0.949 | 0.996 | ↑ |
| Second decile | 1.006 | 0.980 | 1.029 | ↓ |
| Third decile | 0.988 | 1.012 | 1.015 | ↓ |
| Fourth decile | 0.994 | 0.996 | 0.983 | ↓ |
| Fifth decile | 1.006 | 1.017 | 0.986 | ↑ |
| Sixth decile | 1.000 | 1.006 | 0.997 | ↑ |
| Seventh decile | 1.004 | 1.012 | 0.992 | ↑ |
| Eighth decile | 1.003 | 1.014 | 1.002 | ↑ |
| Ninth decile | 1.002 | 1.009 | 1.002 | ↑ |
| Tenth (highest) | 1.001 | 0.991 | 1.003 | ↑ |
| Top 5% | 1.004 | 0.983 | 1.002 | ↑ |
| Top 1% | 0.978 | 0.938 | 0.979 | ↑ |
| Top 0.1% | 0.915 | 0.844 | 0.919 | ↑ |

**Table IX-4. Predictive Ratios by Deciles of Predicted Risk (sorted low to high): Full Benefit Dual, Disabled (Age <65) Continuing Enrollee**

| | 2014/2015 Sample | 2018/2019 Sample | | |
|---|---|---|---|---|
| **Deciles** | **2020 Model** | **2020 Model** | **2024 Model** | **Improvement in Predictive Risk** |
| Entire sample | 1.000 | 0.988 | 1.000 | - |
| First (lowest) decile | 1.076 | 1.008 | 0.967 |  |
| Second decile | 1.016 | 1.004 | 1.053 |  |
| Third decile | 0.893 | 0.869 | 0.904 |  |
| Fourth decile | 0.940 | 0.957 | 0.970 |  |
| Fifth decile | 0.992 | 0.985 | 1.005 |  |
| Sixth decile | 0.999 | 1.010 | 1.005 |  |
| Seventh decile | 1.020 | 0.995 | 1.013 |  |
| Eighth decile | 1.019 | 0.999 | 0.996 |  |
| Ninth decile | 1.008 | 1.014 | 1.016 |  |
| Tenth (highest) | 1.002 | 0.983 | 1.002 |  |
| Top 5% | 0.996 | 0.974 | 0.995 |  |
| Top 1% | 0.984 | 0.954 | 0.983 |  |
| Top 0.1% | 0.873 | 0.986 | 1.007 |  |

**Table IX-5. Predictive Ratios by Deciles of Predicted Risk (sorted low to high): Partial Benefit Dual, Aged (Age >=65) Continuing Enrollee**

| | 2014/2015 Sample | 2018/2019 Sample | | |
|---|---|---|---|---|
| **Deciles** | **2020 Model** | **2020 Model** | **2024 Model** | **Improvement in Predictive Risk** |
| Entire sample | 1.000 | 0.992 | 1.000 | - |
| First (lowest) decile | 0.998 | 0.942 | 1.000 |  |
| Second decile | 0.998 | 0.987 | 1.023 |  |
| Third decile | 0.977 | 0.933 | 0.999 |  |
| Fourth decile | 0.987 | 0.992 | 1.001 |  |
| Fifth decile | 0.999 | 0.989 | 0.976 |  |
| Sixth decile | 1.004 | 1.016 | 0.983 |  |
| Seventh decile | 1.003 | 1.013 | 1.006 |  |
| Eighth decile | 1.006 | 1.017 | 1.000 |  |
| Ninth decile | 1.006 | 1.021 | 1.009 |  |
| Tenth (highest) | 0.999 | 0.968 | 1.000 |  |
| Top 5% | 0.994 | 0.951 | 1.000 |  |
| Top 1% | 0.999 | 0.931 | 0.985 |  |
| Top 0.1% | 0.981 | 0.870 | 0.981 |  |

**Table IX-6. Predictive Ratios by Deciles of Predicted Risk (sorted low to high): Partial Benefit Dual, Disabled (Age <65) Continuing Enrollee**

| | 2014/2015 Sample | 2018/2019 Sample | | |
|---|---|---|---|---|
| **Deciles** | **2020 Model** | **2020 Model** | **2024 Model** | **Improvement in Predictive Risk** |
| Entire sample | 1.000 | 0.988 | 1.000 | - |
| First (lowest) decile | 0.935 | 0.878 | 0.989 |  |
| Second decile | 1.020 | 1.023 | 0.896 |  |
| Third decile | 0.988 | 0.955 | 1.045 |  |
| Fourth decile | 0.979 | 0.991 | 1.002 |  |
| Fifth decile | 0.982 | 0.979 | 0.996 |  |
| Sixth decile | 0.999 | 0.988 | 1.003 |  |
| Seventh decile | 1.011 | 1.012 | 0.999 |  |
| Eighth decile | 1.025 | 1.032 | 0.996 |  |
| Ninth decile | 1.010 | 1.019 | 1.022 |  |
| Tenth (highest) | 0.996 | 0.963 | 1.000 |  |
| Top 5% | 0.989 | 0.944 | 0.997 |  |
| Top 1% | 1.002 | 0.939 | 0.981 |  |
| Top 0.1% | 1.076 | 0.932 | 0.968 |  |

**Table IX-7. Predictive Ratios by Deciles of Predicted Risk (sorted low to high): Institutional Continuing Enrollee**

| | 2014/2015 Sample | 2018/2019 Sample | | |
|---|---|---|---|---|
| **Deciles** | **2020 Model** | **2020 Model** | **2024 Model** | **Improvement in Predictive Risk** |
| Entire sample | 1.000 | 0.951 | 1.000 | - |
| First (lowest) decile | 0.858 | 0.788 | 0.824 | ↑ |
| Second decile | 0.959 | 0.877 | 0.932 | ↑ |
| Third decile | 0.995 | 0.928 | 0.977 | ↑ |
| Fourth decile | 1.000 | 0.949 | 1.011 | ↑ |
| Fifth decile | 1.022 | 0.968 | 1.029 | ↑ |
| Sixth decile | 1.023 | 0.976 | 1.035 | ↓ |
| Seventh decile | 1.026 | 0.982 | 1.028 | ↓ |
| Eighth decile | 1.020 | 0.975 | 1.028 | ↓ |
| Ninth decile | 1.015 | 0.970 | 1.014 | ↑ |
| Tenth (highest) | 0.989 | 0.952 | 0.992 | ↑ |
| Top 5% | 0.984 | 0.939 | 0.978 | ↑ |
| Top 1% | 0.967 | 0.900 | 0.918 | ↑ |
| Top 0.1% | 0.954 | 0.865 | 0.859 | ↓ |

**NOTES**:

1. "Improvement in Predictive Risk" compares the distance the predictive ratios are from 1.0 for the 2024 model and 2020 model with a 2018 – 2019 sample.
2. For example, a green arrow indicates that the predictive ratio for any specific decile for the 2024 model is closer to 1.0 than the predictive ratio for the 2020 model with a 2018 – 2019 sample, and vice-versa.