January 31, 2024

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

SUBJECT: Advance Notice of Methodological Changes for Calendar Year (CY) 2025 for Medicare Advantage (MA) Capitation Rates and Part C and Part D Payment Policies

In accordance with section 1853(b)(2) of the Social Security Act (the Act), we are notifying you of planned changes in the Medicare Advantage (MA) capitation rate methodology and risk adjustment methodology applied under Part C of the Medicare statute for CY 2025. Also included with this notice is a discussion of the annual adjustments for CY 2025 to the Medicare Part D benefit parameters for the defined standard benefit, including those necessitated by the Inflation Reduction Act of 2022 (IRA) (Pub. L. 117-169). CMS will announce the MA capitation rates and final payment policies for CY 2025 no later than Monday, April 1, 2024, in accordance with section 1853(b) of the Act, as established in the Medicare Prescription Drug, Improvement, and Modernization Act of 2003 (MMA) (Pub. L. 108-173) and amended by the Securing Fairness in Regulatory Timing Act of 2015 (Pub. L. 114-106). The Advance Notice of Methodological Changes is published no fewer than 60 days before the publication of the final Announcement of CY 2025 Medicare Advantage Capitation Rates and Part C and Part D Payment Policies (Rate Announcement) and provides a minimum 30-day period for public comment.

Attachment I of this document shows the preliminary estimates of the national per capita MA growth percentage and the national Medicare fee-for-service growth percentage, which are key factors in determining the MA capitation rates. Attachment II sets forth changes in the Part C payment methodology for CY 2025. Attachment III presents the annual adjustments to the Medicare Part D benefit parameters for the defined standard benefit and sets forth the changes in the Part D payment methodology for CY 2025, including those necessitated by the IRA, such as an update to the Part D risk adjustment (RxHCC) model. For additional information about Part D policies related to the IRA for 2025, such as the reduction of the annual out-of-pocket threshold to $2,000, elimination of the coverage gap phase, and changes in the new standard Part D benefit design, see the Draft CY 2025 Part D Redesign Program Instructions being released concurrently with this Advance Notice. Attachment IV applies standards for certain updates for the MA and Part D Star Ratings and solicits feedback on potential new measures, substantive and non-substantive updates to existing measures, and potential measure concepts. Attachment V contains economic information for significant provisions in the Advance Notice. Attachment VI presents the preliminary risk adjustment factors.

As with prior Advance Notices and Rate Announcements, we are releasing a Fact Sheet and Frequently Asked Questions (FAQs), available through the Newsroom webpage on the CMS.gov website, to accompany this CY 2025 Advance Notice. The Fact Sheet provides additional

information on the impact of the policies and updates on individual payment factors, such as the growth rates and risk adjustment changes, including the MA risk score trend, and also the overall average impact of the factors on MA revenue.

To submit comments or questions electronically, go to https://www.regulations.gov, enter the docket number "CMS-2024-0006" in the "Search" field, and follow the instructions for "submitting a comment."

Comments will be made public, so submitters should not include any confidential or personal information. It should be noted that CMS will not post on Regulations.gov public comments that make threats to individuals or institutions or suggest that the individual will take actions to harm the individual. In order to receive consideration prior to the release of the Rate Announcement, comments on this Advance Notice must be received by 6:00 PM Eastern Time on Friday, March 1, 2024.

/ 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 Advance Notice. My opinion is limited to the following sections of this Advance Notice: The growth percentages and United States per capita cost estimates provided in Attachment I; 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, Employer Group Waiver Plan (EGWP) rates, and ESRD rates discussed in Attachment II; Medicare Part D Benefit Parameters: Annual Adjustments for Defined Standard Benefit in 2025 described in Attachment III; and the economic information contained in Attachment V. As noted in Attachment I, the Secretary has directed the CMS Office of the Actuary to phase in the MA-related medical education technical update to the historical and projected expenditures supporting the estimates of the USPCCs which are used in determining the growth percentages.

/ s /
Jennifer Wuggazer Lazio, F.S.A., M.A.A.A.
Director
Parts C & D Actuarial Group
Office of the Actuary

Attachments

2025 ADVANCE NOTICE
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Attachment I. Preliminary Estimates of the National Per Capita Growth Percentage and the National Medicare Fee-for-Service Growth Percentage for Calendar Year 2025

Each year in the Advance Notice, CMS updates its historical estimates of per capita Medicare costs based on recent data and provides an estimate for an additional projection year. Specifically, CMS provides estimates of three separate United States Per Capita Costs (USPCCs) for each calendar year:

- Non-ESRD
    - **FFS USPCC**: the USPCC for Medicare Fee-for-Service (FFS) aged/disabled beneficiaries except those beneficiaries who are in End Stage Renal Disease (ESRD) status for payment purposes, i.e., those beneficiaries who are in dialysis, transplant, or functioning graft status. The FFS USPCC is used in the calculation of the specified amount in years in which CMS elects to rebase the adjusted average FFS per capita cost. CMS intends to rebase as part of the calculation of the rates for 2025. The specified amount is described in Attachment II Section A2 and is sometimes referred to as the "post Affordable Care Act (ACA)" rate methodology. The FFS USPCC is also used in the calculation of the applicable amount, as described in Attachment II Section A1.
    - **Total USPCC**: the USPCC for Medicare Part C and FFS aged/disabled beneficiaries except those beneficiaries who are in ESRD status for payment purposes. The Total USPCC is used to calculate the national per capita growth percentage, also known as the national per capita Medicare Advantage growth percentage, which is used in the calculation of the applicable amount. See Attachment II Section A1 for details regarding the calculation of the applicable amount, which is sometimes referred to as the "pre-ACA" rate methodology used to determine the "benchmark cap" for each county, as described in Attachment II Section A5.
- ESRD
    - **FFS Dialysis ESRD USPCC**: the USPCC for beneficiaries in FFS with ESRD who are in dialysis status (i.e., "Dialysis ESRD").[1]

Based on these estimates, CMS calculates the change, or growth, in each of the USPCCs for the upcoming year. In this Notice, we provide growth percentages from 2024 to 2025. These growth percentages represent the year-over-year changes to the USPCCs used to calculate the MA payment rates, or benchmarks, as discussed below. Throughout this document, we use the terms

[1] Dialysis ESRD USPCCs are trended from a base year using the trend in total ESRD net of an adjustment factor for dialysis-only.

"benchmark" and "county rate" interchangeably, and the term "service area benchmark" indicates the bidding benchmark for an MA plan based on its specific service area.

The MA county rates are based on the specified amount as described in Attachment II Section A2 below. Section 1853(n)(2)(A) of the Social Security Act ("the Act") defines the specified amount as the base amount multiplied by the applicable percentage for the area (set under section 1853(n)(2)(B) through (D)). Section 1853(n)(4) requires that the benchmark for an area for a year (including increases for quality bonus percentages) be capped at the level of the applicable amount, as defined at section 1853(k)(1) and described in Attachment II Section A1.

The county rates for Programs of All-Inclusive Care for the Elderly (PACE) are established using the applicable amount as determined under section 1853(k)(1). This amount is calculated without excluding indirect medical education (IME) amounts under section 1853(k)(4) (as required by section 1894(d)(3)), or organ acquisition costs for kidney transplants, as discussed in Attachment II Section C of this document.

Section A. Data and Assumptions Supporting USPCCs

Background

In this section of the CY 2025 Advance Notice, we provide details and descriptions regarding the development of the USPCCs. Unless otherwise stated, the data and methodologies described in this section are a continuation of the data and methodologies used in the prior year. The historical and projected USPCCs are based on the most recent program experience and actuarial projections prepared by the Office of the Actuary (OACT). The data is tabulated and projected separately for Medicare Part A and Medicare Part B on a quarterly basis. Enrollment and expenditures are summarized on an incurred basis.

Historical Enrollment

Historical total Medicare enrollment is developed from CMS's administrative records. Historical MA enrollment is tabulated from the Monthly Membership Report (MMR[2]) data files.

The enrollment is summarized separately for total Medicare and for MA and apportioned to non-ESRD and ESRD categories based on Medicare Status Code (MSC):

- Non-ESRD: MSC 10 (aged without ESRD) and MSC 20 (disabled without ESRD)
- ESRD: MSC 11 (aged with ESRD), MSC 21 (disabled with ESRD), and MSC 31 (ESRD only)

[2] For more information on the MMR, refer to the Plan Communication User Guide available at https://www.cms.gov/Research-Statistics-Data-and-Systems/CMS-Information-Technology/mapdhelpdesk/Plan_Communications_User_Guide

Historical Medicare FFS enrollment is calculated as the difference between total Medicare enrollment and MA enrollment.

Projected Enrollment

Total Medicare enrollment projections are generally based on certain percentages of the Social Security Administration's (SSA's) population projections. The percentages used to project total Medicare enrollment as percentages of SSA's population projections have been stable over time. For Part A, the projected number of aged beneficiaries averages 97 percent of the Social Security area population[3] aged 65 and older. The disabled enrollment projection is slightly more than the portion of SSA's disabled beneficiary population that has been on the rolls for at least 2 years, because an individual is eligible for Part A even if they have had 2 non-consecutive years of disability. For Part B, the aged enrollment averages 90 percent of the Social Security area population aged 65 and older. The Part B disabled enrollment is 92 percent of the Part A disabled enrollment.

The increase in the MA projected enrollment is based on an enrollment model which incorporates the historical growth in penetration rates to estimate the MA enrollment growth rates for future years. Projected Medicare FFS enrollment is calculated as the difference between projected total Medicare enrollment and projected MA enrollment.

Historical Benefit Expenditures

The primary source for historical FFS claims is the National Claims History (NCH) file.[4] Additional sources of FFS expenditures include payments to providers based on cost reports, payments for pass through costs, and payment adjustments authorized by law or in connection with participation in the Medicare Shared Savings Program or Innovation Center models or demonstrations or Advanced Alternative Payment Models. Using completion factors developed from recent program experience, historical experience for more recent years is grossed up to account for claims incurred but not paid.

Historical MA expenditures are tabulated from the Monthly Membership Report (MMR) files, which is the same source as for MA historical enrollment. The historical experience for more recent years is grossed up to reflect estimated outstanding risk adjustment reconciliations.

[3] Social Security area population is defined in the Glossary of the 2023 OASDI Trustees Report (The 2023 Annual Report of the Board of Trustees of the Federal Old-Age and Survivors Insurance and Federal Disability Insurance Trust Funds) available at https://www.ssa.gov/OACT/TR/2023/VI_I_glossary.html

[4] For more information on the NCH, refer to the System of Records Notice available at https://www.hhs.gov/foia/privacy/sorns/09700558/index.html

Projected Benefit Expenditures

Projected expenditures for FFS beneficiaries are developed separately for each type of service reflected in the NCH file, cost report settlements, pass through costs, and payments in the Medicare Shared Savings Program or Innovation Center models or demonstrations or Advanced Alternative Payment Models.[5]

The projection of NCH costs is based on reimbursements or allowed charges incurred per beneficiary during the base calendar year (CY). For the 2025 Advance Notice USPCCs, the base year for expenditures is CY 2022 for most services.

The projections take into account various trends including:

- Unit cost changes tied to market baskets and productivity adjustments, fee schedule updates, or the consumer price index (CPI). These updates are based on economic assumptions provided by the Office of Management and Budget (OMB).
- Utilization and intensity of services, which are generally based on historical trends.
- Impact of changes in population mix as measured by age, sex, and time-to-death.
- Changes in Medicare coverage due to legislation, regulation, and national coverage determinations (NCDs).

Projected cost report settlements and pass through costs are developed as a percentage add-on basis to the NCH costs and are projected to remain at the same percentage level throughout the projection.

Innovation Center model or demonstration payments are projected based on the estimates developed for each individual Innovation Center model or demonstration and any historical experience of each model or demonstration.

MA per capita historical bids, rebates, and benchmarks are summarized on an incurred basis by Medicare Status Code, insurance market (EGWP, individual/non-EGWP), and coverage/plan type (HMO, LPPO, RPPO, SNP, etc.). Projections are performed separately for payments from the Part A and Part B Trust Funds[6]. Aggregate projected MA payments are calculated as the projected MA per capita costs times the projected enrollment.

CY 2022 is the base year for expenditures for the MA experience reflected in the 2025 Advance Notice. The 2023 and 2024 risk-adjusted benchmarks, bids, and rebates are estimated based on the growth rates that are derived from the summarized 2023 and 2024 bids and using plans' projections of enrollment and risk scores. Trends in per capita bids for 2025 and later are tied to

[5] Attachment II Section B3 contains additional information regarding the Medicare Shared Savings Program and Innovation Center models and demonstrations, and Advanced Alternative Payment Models.

[6] MA and PACE plans receive prospective capitated payments for enrollees from the Hospital Insurance (HI) and Supplementary Medical Insurance (SMI) trust fund accounts.

the per capita FFS growth rates, calculated using the non-ESRD FFS USPCCs and the per capita benchmark increases. Trends in the MA benchmarks reflect the FFS growth rates, adjustment to MA risk scores for differences in diagnosis coding between MA and FFS beneficiaries, projected changes in ACA quality bonus (county-specific), and projected phase-out of IME (county-specific).

The Medicare FFS unit cost increases supporting the USPCCs for 2023—2025 will be available on the CMS website at: https://www.cms.gov/Medicare/Health-Plans/MedicareAdvtgSpecRateStats/FFS-Trends.

Adjustments from the Program Baseline to Develop the USPCC Baseline

There are several adjustments made to the program baseline to develop the USPCC projection. Given that MA bids do not include coverage for hospice, payments to hospices are excluded from the USPCCs. Also, per section 1853(c)(1)(D)(i) of the Act, incentive payments under sections 1848(o) and 1886(n) of the Act[7] for adoption and meaningful use of certified EHR technology are not included in the USPCCs. Additionally, claim expenditures in the NCH for cost plan enrollees are removed from the non-ESRD FFS USPCC. Finally, the MA ratebook and MA bids are presented on a pre-sequestration basis and, accordingly, the historical and projected sequestration reduction is added back to the USPCC baseline.

Technical Update to Medical Education Payments in the Non-ESRD USPCC Baseline

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 direct graduate medical education (DGME) costs associated with services furnished to MA enrollees. These MA medical education expenditures are not costs for FFS beneficiaries.

Prior to the CY 2024 ratebook, the tabulation of non-ESRD FFS USPCCs had included both IME and DGME costs paid to inpatient facilities on behalf of MA enrollees because the inpatient cost report experience supporting the baseline modeling did not separately identify these payments from those made on behalf of FFS enrollees. Consequently, MA organizations had been effectively paid for these admissions-related costs, even though CMS and not MA organizations, had been paying these costs associated with MA enrollees directly to hospitals.

[7] Sections 1848(o) and 1886(n) of the Act provide for incentive payments under the Medicare FFS program for eligible professionals and eligible hospitals, respectively, for meaningful use of certified EHR technology (CEHRT). 2016 was the final year that eligible professionals, as well as eligible hospitals outside of Puerto Rico, could earn incentive payments under these provisions; eligible hospitals in Puerto Rico could earn incentive payments for meaningful use of CEHRT through 2021. Sections 1848(a)(7) and 1886(b)(3)(B)(ix) require a reduction in Medicare FFS payments for eligible professionals and eligible hospitals that are not meaningful users of certified EHR technology, starting in 2015 for eligible professionals and eligible hospitals outside of Puerto Rico and in 2022 for eligible hospitals in Puerto Rico. 2018 was the final year that eligible professionals who were not meaningful users of CEHRT could be subject to negative payment adjustments under section 1848(a)(7).

Beginning with the CY 2024 ratebook, the baseline development and modeling supporting the USPCCs has been updated to separate these payments and identify the historical and projected costs of IME and DGME paid to inpatient facilities by CMS associated with services furnished to MA enrollees.

On pages 10-11 of the CY 2024 Advance Notice,[8] we proposed to remove these MA-related IME and DGME costs from the historical and projected expenditures supporting the non-ESRD FFS USPCCs beginning with the CY 2024 ratebook. In the CY 2024 Rate Announcement,[9] we finalized the technical update to remove MA-related IME and DGME costs from the historical and projected expenditures supporting the non-ESRD FFS USPCCs. The Secretary directed the CMS Office of the Actuary to phase in this technical update to the USPCCs over a 3-year period beginning with the CY 2024 ratebook, with 33% of the MA-related medical education adjustment applied to the USPCCs in 2024.

We indicated on page 3 of the CY 2024 Rate Announcement that we intended to continue the phase-in by increasing to 67% for the 2025 MA-related medical education adjustment to be applied in 2025 and 100% of the 2026 value to be applied in 2026. We propose to apply 67% of the MA-related medical education adjustment in 2025.

The effects of the phase-in of 67% of the MA-related medical education adjustment on the USPCCs reflected in Section B of this document include:

- First, the technical change lowers the 2025 non-ESRD FFS USPCC and the corresponding non-ESRD FFS growth percentage by 0.96 percent (compared to the 2025 growth percentage with 33% phase-in). This growth percentage is used in the calculation of the specified amount for all counties.
- Second, the technical change lowers the 2025 non-ESRD Total USPCC and the corresponding MA growth percentage by 0.43 percent (compared to the 2025 growth percentage with 33% phase-in). This growth percentage is used in the calculation of the applicable amounts which serve as a cap on the specified amount for a subset of affected counties.

This technical change is not expected to have any impact on the 2025 dialysis ESRD USPCC.

The changes described in this section have no impact on the exclusion of medical education costs from the Average Geographic Adjustments (AGAs) used to create the ratebook, since the adjustment proposed in this section is limited to the USPCCs. Refer to Attachment II, Sections C1 (Direct Graduate Medical Education) and C3 (Indirect Medical Education) for descriptions of the adjustments to the AGAs pertaining to the FFS experience and projections used to develop the ratebook. As we explained on page 31 of the CY 2024 Rate Announcement, the adjustments

[8] The CY 2024 Advance Notice is available at https://www.cms.gov/files/document/2024-advance-notice-pdf.pdf

[9] The CY 2024 Rate Announcement is available at https://www.cms.gov/files/document/2024-announcement-pdf.pdf

to the USPCCs and AGAs pertain to two different groups of Medicare beneficiaries: the technical update to the non-ESRD FFS USPCC pertains to excluding IME and DGME costs associated with *MA enrollees* (paid directly by CMS to hospitals), whereas the county level adjustment to the AGA pertains to IME and DGME costs associated with *FFS beneficiaries* (paid directly by CMS to hospitals) to determine MA capitation rates using FFS per capita costs as required by section 1853 of the Act.

In addition, the AGA adjustments are developed using different sources of FFS data that are better suited to the separate calculations. Prior to the CY 2024 ratebook, IME and DGME payments included in the non-ESRD FFS USPCCs were sourced from historical inpatient cost reports that had included amounts paid on behalf of both FFS and MA enrollees. The cost reports are used as a source for the projections of the USPCCs since the data contains more detail of the various components of hospital payments that are projected separately, including capital, bad debt, and ancillary pass-through payments. In contrast, the IME and DGME payments used to calculate the ratebook IME and DGME carve-out factors applied to the AGAs are sourced from the FFS claims records and, as such, the adjustment in the county FFS rate calculation has always been limited to the payments for FFS admissions. The claim records are used in the ratebook medical education exclusion because the claim records include the beneficiary's county of residence. Therefore, no corresponding adjustment is required to the IME phase-out and DGME carve-out adjustments to the AGAs in the county ratebook calculation to remove costs associated with MA enrollees. Thus, the technical update to the USPCC has no impact on the exclusion of medical education costs from the AGAs used to develop the ratebook.

The following table illustrates the development of the current estimate of the CY 2025 Part A non-ESRD FFS USPCC with the implementation of the technical update.

Table I-1. CY 2025 Part A non-ESRD FFS USPCC Estimate Development

Projection for Contract Year 2025	With 33% implementation of technical update (*informational*)	With 67% implementation of technical update *for CY 2025 rates*	With full (100%) implementation of technical update (*informational*)
a. Part A FFS Enrollment (annual, in millions)	32.495	32.495	32.495
Reimbursements (in millions):			
b. Part A reimbursements including all MA medical education	$179,952.70	$179,952.70	$179,952.70
c. MA medical education amount (as a negative number)	($4,009.80)	($8,141.12)	($12,150.92)

Projection for Contract Year 2025	With 33% implementation of technical update (*informational*)	With 67% implementation of technical update *for CY 2025 rates*	With full (100%) implementation of technical update (*informational*)
d. Part A reimbursements excluding MA medical education *d = (b + c)*	$175,942.89	$171,811.58	$167,801.77
e. Part A FFS Admin loading	1.001102	1.001102	1.001102
f. 2025 Part A non-ESRD FFS USPCC *f = [(d * e) / a / 12]*	$451.71	$441.10	$430.81
g. 2025 Part B non-ESRD FFS USPCC	$692.35	$692.35	$692.35
h. 2025 non-ESRD FFS USPCC *h = f + g*	$1,144.06	$1,133.45	$1,123.16
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 *j = h/i – 1 (rounded to hundredth of a percent)*	3.53%	2.57%	1.63%
k. Impact of increase in phase-in on CY 2025 FFS growth rate (compared with 33% phase-in)	n/a	-0.96%	-1.90%

The impact of the increase in the phase-in on the CY 2025 MA growth percentage (based on the change in the non-ESRD Total USPCC, which includes both FFS and Part C projections) compared to the 2025 growth percentage with 33% phase-in is -0.84 percent for full (100%) implementation of the medical education change (provided for informational purposes) and –0.43% for 67% implementation in CY 2025.

Section B. 2025 Growth Percentage Estimates

The MA growth percentage, as defined at section 1853(c)(6), reflects the growth in per capita costs for non-ESRD beneficiaries enrolled in either FFS or Medicare health plans[10], excluding expenditures attributable to sections 1848(a)(7), 1848(o), 1886(b)(3)(B)(ix), and 1886(n) of the Act, based upon estimates of the Total USPCC. The MA growth percentage is also referred to as the total growth percentage and the National Per Capita MA Growth Percentage. The MA growth percentage is used in calculating the applicable amount for a county, as required under section 1853(k)(1).

The non-ESRD FFS growth percentage reflects the growth in per capita costs based upon estimates of the non-ESRD FFS USPCC. As required by section 1853(n)(2)(E)(ii)(II) of the Act, the FFS USPCC calculated under section 1853(c)(1)(D) is used to calculate the specified amount in years in which CMS elects to rebase the adjusted average FFS per capita cost. CMS intends to rebase as part of the calculation of the rates for 2025.

The ESRD growth percentage reflects the growth in per capita costs based on the ESRD FFS USPCC. MA ESRD rates are determined by applying an historical average geographic adjustment to a projected FFS dialysis-only ESRD USPCC.

Table I-2 below provides the current estimate of the change in the three USPCC estimates. The percentage change in each USPCC is shown as the current projected USPCC for 2025 divided by the prior projected USPCC for 2024.

Table I-2. Increase in the USPCC Growth Percentage for CY 2025

	Total USPCC – Non-ESRD	FFS USPCC – Non-ESRD	FFS Dialysis-only ESRD USPCC
Current projected 2025 USPCC	$1,179.00	$1,133.45	$9,842.94
Prior projected 2024 USPCC	$1,156.15	$1,105.10	$9,544.97
Percent increase	1.98%	2.57%	3.12%

The current estimate of the MA growth percentage* (or change in the Total USPCC non-ESRD) for aged and disabled enrollees combined in CY 2025 is 1.98 percent. This estimate reflects an underlying trend change for CY 2025 in per capita cost of 3.50 percent and, as required under section 1853(c)(6)(C) of the Act, adjustments to the estimates for prior years as indicated in the table below.

[10] "Medicare health plans" include MA plans, Cost plans, PACE plans, and MMP plans.

Table I-3 below provides additional detail on the estimates for the change in the Total USPCC non-ESRD or national per capita MA growth percentage for aged/disabled beneficiaries.

Table I-3. Increase in the MA Growth Percentage for 2025

	Prior Increases	Current Increases			MA Growth Percentage for 2025 With §1853(c)(6)(C) adjustment**
	2003 to 2024	2003 to 2024	2024 to 2025	2003 to 2025	
Aged+Disabled	112.590%	109.462%	3.499%	116.792%	1.98%

* The MA growth percentage is also known as the National Per Capita MA Growth Percentage and is equal to change in the Total USPCC non-ESRD.

** (1 + current increases for 2003 to 2025) divided by (1 + prior increases for 2003 to 2024) minus 1.

Section C. USPCC Estimates

Table I-4 compares last year's estimate of the Total non-ESRD USPCC with current estimates for 2003 to 2027; Table I-5 compares last year's FFS non-ESRD USPCC estimates with current estimates; and Table I-6 compares last year's dialysis-only ESRD USPCC estimates with current estimates. In addition, these tables show the current projections of the USPCCs through 2027. 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 prescription drug benefit.

The tabulation of FFS costs supporting the USPCCs includes payments made outside the Medicare FFS claim systems, such as provider settlements via cost reports, Innovation Center model and demonstration payments, Medicare Shared Savings Program shared savings settlements, Advanced Alternative Payment Model incentive payments, and other adjustments. Also included in the USPCCs are the cost impacts of program changes enacted through known legislation, regulation, and NCDs applicable for the contract year (2025). Attachment II Section B contains additional information regarding the calculation of FFS costs used in setting MA rates and benchmarks.

COVID-19

Our estimates for the USPCCs for 2020 and subsequent years reflect the projected cost impacts related to the COVID-19 pandemic, including estimates for applicable costs related to COVID-19 vaccination and changes in utilization of health care services. These USPCCs also reflect estimated cost impacts of changes in MA coverage created by legislation in Section 3713 of the CARES Act, which amended section 1852(a)(1)(B) of the Act, that prohibits MA organizations

from requiring cost-sharing in excess of Medicare FFS cost-sharing (which is zero) for a COVID-19 vaccine and its administration described in section 1861(s)(10)(A) of the Act; this limitation on cost sharing is not limited to the Public Health Emergency (PHE) and, therefore, will apply in 2025.

Part B Provisions of the Inflation Reduction Act

Our estimates for the USPCCs for 2022 and subsequent years reflect the projected cost impacts related to the Part B provisions of the IRA that are effective in those years. For example, section 11101 of Subtitle B of the IRA requires manufacturers of a "Part B rebatable drug"[11] to pay a rebate if 106 percent of the lesser of the drug's average sales price or wholesale acquisition cost (or, for biologicals, 100 percent of the biosimilar's average sales prices +6 percent of the reference product's average sales price) for a calendar quarter exceeds the inflation-adjusted payment amount;[12] this provision applies for each calendar quarter beginning on or after January 1, 2023. In addition, if 106 percent of the lesser of the drug's average sales price or wholesale acquisition cost (or, for biologicals, 100 percent of the biosimilar's average sales prices +6 percent of the reference product's average sales price) for a calendar quarter exceeds the inflation-adjusted payment amount, then, beginning April 1, 2023, beneficiary coinsurance is to be based on the inflation-adjusted payment amount. Also, section 11407 of the IRA requires that, beginning July 1, 2023, the Medicare Part B deductible does not apply for insulin furnished through an item of durable medical equipment covered under Medicare's durable medical equipment benefit, and beneficiary cost sharing for a month's supply of insulin is not to exceed $35.

Section 11407 of the IRA is projected to increase Part B FFS expenditures for 2023 and subsequent years because Medicare will pay for the reduced beneficiary financial responsibility for insulins. Section 11101 is projected to have a negligible downward impact on Part B FFS expenditures for 2023 and subsequent years.

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

In light of the Supreme Court's decision in *American Hospital Association v. Becerra* on June 15, 2022, and the district court's remand to the agency, CMS issued the Hospital Outpatient Prospective Payment System Remedy for the 340B-Acquired Drug Payment Policy for Calendar

[11] Per section 1847A(i)(2) of the Act, a "Part B rebatable drug" is defined as a single source drug or biological including biosimilars (excluding a qualifying biosimilar biological product as defined in 1847A(b)(8)(B)(iii)); a drug or biological with average annual spending less than $100 per individual user (as determined by the Secretary) and preventive Part B vaccines are excluded from this definition.

[12] The inflation-adjusted amount is the payment amount in the benchmark quarter (in general, the calendar quarter beginning July 1, 2021) increased by CPI-U.

Years 2018-2022 Final Rule, CMS-1793-F, on November 2, 2023.[13] CMS will make a one-time lump sum payment to each affected provider that reflects the difference between what covered entities were paid for 340B drugs (generally ASP minus 22.5%) and what they would have been paid had the 340B payment policy not been applied (generally ASP plus 6%) from 2018 through September 27, 2022. CMS will budget neutralize the remedy under Sections 1833(t)(2)(E) and 1833(t)(14)(H) of the Act, and, alternatively, under the agency's inherent or common-law recoupment authorities. CMS will do so by reducing non-drug outpatient item and service prospective payments beginning in 2026. For more information on the remedy, please see: https://www.cms.gov/newsroom/fact-sheets/hospital-outpatient-prospective-payment-system-opps-remedy-340b-acquired-drug-payment-policy.

The FFS USPCCs are developed consistent with the final regulation CMS-1793-F. In the CY 2025 Advance Notice, the restatements ("current estimates") of the FFS USPCCs for years 2018 - 2022 reflect the lump sum 340B-acquired drug remedy payments for services rendered from January 1, 2018 through September 27, 2022 for each 340B covered entity. The lump sum remedy payments are reflected in the USPCCs of the respective year associated with the service experience, and as such the 2025 USPCCs and 2025 growth rates are not expected to be impacted. Additionally, the USPCCs projected for years 2026 and later reflect a reduction for all non-drug items and services to all OPPS providers, except new providers, by 0.5 percent each year until the entire 340B-acquired drug offset is reached.

USPCC Estimates

Table I-4. 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

[13] 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.

	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
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	400.80	400.79	525.05	521.89	925.85	922.68	1.003
2020	404.11	403.90	525.19	522.48	929.30	926.38	1.003
2021	410.02	409.38	572.48	569.14	982.50	978.52	1.004
2022	433.79	431.47	607.53	603.83	1,041.32	1,035.30	1.006
2023	452.33	459.23	660.36	658.56	1,112.69	1,117.79	0.995
2024	455.24	464.05	683.90	692.10	1,139.14	1,156.15	0.985
2025	457.89	480.98	721.11	729.01	1,179.00	1,209.99	0.974
2026	467.00	496.85	766.30	772.41	1,233.30	1,269.26	0.972
2027	489.00		814.62		1,303.62		

Table I-5. 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	383.84	380.01	506.20	500.82	890.04	880.83	1.010
2020	375.86	370.93	478.49	473.65	854.35	844.58	1.012
2021	390.91	384.05	557.21	550.73	948.12	934.78	1.014
2022	407.54	398.10	578.89	573.64	986.43	971.74	1.015
2023	423.83	428.63	633.29	629.07	1,057.12	1,057.70	0.999
2024	435.00	440.70	657.21	664.40	1,092.21	1,105.10	0.988
2025	441.10	451.09	692.35	698.89	1,133.45	1,149.98	0.986

	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
2026	450.27	459.88	735.17	739.42	1,185.44	1,199.30	0.988
2027	471.11		780.12		1,251.23		

Table I-6. 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	3,393.27	3,395.47	4,828.65	4,863.56	8,221.92	8,259.03	0.996
2023	3,436.40	3,632.99	5,151.03	5,296.62	8,587.43	8,929.61	0.962
2024	3,649.83	3,835.56	5,271.18	5,709.41	8,921.01	9,544.97	0.935
2025	3,832.00	4,084.94	6,010.94	6,778.51	9,842.94	10,863.45	0.906
2026	4,054.48	4,347.69	6,285.28	7,309.00	10,339.76	11,656.69	0.887
2027	4,281.87		6,576.77		10,858.64		

These estimates are preliminary and could change when the final rates are announced in the Announcement of CY 2025 Medicare Advantage Capitation Rates and Medicare Advantage and Part D Payment Policies. Further details on the derivation of the national per capita MA growth percentage and the FFS growth percentage will also be presented in the Rate Announcement.

Section D. Loading for Claims Processing Costs

Section 1853(c)(1)(D) of the Act provides that the adjusted average per capita cost (AAPCC) for the year involved, which is the basis for the calculation of the USPCC, is determined under section 1876(a)(4) of the Act. As defined in section 1876(a)(4) of the Act, the AAPCC (and

accordingly the USPCCs) include administrative costs incurred by the Medicare Administrative Contractors (MACs) described in sections 1816 and 1842, which are incorporated into the calculation as an adjustment. Consistent with past practice, this "loading" adjustment is developed as the ratio of MAC administrative costs to Medicare benefit payments for the most recent completed fiscal year. Consistent with past years, we will continue the methodology that the loading for the Total non-ESRD USPCC include both FFS and Part C expenditures in the denominator of the calculation. In order to better align the costs included in the numerator and denominator, we will continue to include, as adopted for the 2023 rates, only FFS expenditures (as opposed to both FFS and Part C expenditures) in the denominator of the loading adjustment calculation for the FFS non-ESRD and FFS ESRD USPCCs. Table I-7 contains the proposed 2025 USPCC loading adjustment for claims processing costs.

Table I-7. USPCC Loading Adjustment for Claims Processing Costs

Expenditure Category	Cash Benefits FY 2023 (000)	MAC Expenses FY 2023 (000)	Claims Processing Loading	USPCC basis
PART A				
FFS	$206,650,625	$227,725	0.001102	FFS USPCC
Part C	$186,430,022	n/a	n/a	n/a
Total	$393,080,647	$227,725	0.000579	Total USPCC
PART B				
FFS	$222,726,406	$649,472	0.002916	FFS USPCC
Part C	$265,445,369	n/a	n/a	n/a
Total	$488,171,775	$649,472	0.001330	Total USPCC

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

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

Section 1853(n)(2) of the Act requires that, in determining the specified amount, CMS use as the base amount the amount described in section 1853(c)(1)(D) for a rebasing year or, for years that are not a rebasing year, the base amount from the previous year increased by the national per capita MA growth percentage. Section 1853(c)(1)(D)(ii) requires CMS to rebase the county FFS rates, which form the basis of the specified amount described in Section A2 below, periodically but not less than once every three years. When the rates are rebased, CMS updates its estimate of each county's FFS costs using more current FFS claims information. CMS intends to rebase the county FFS rates for 2025 using FFS claims data from 2018 through 2022. CMS has rebased the rates every year since 2012 and has discussed in previous Rate Announcements that we anticipate rebasing the rates each year. Given that MA rates are based on FFS costs, CMS believes it is important to update the FFS per capita cost estimates using the most current FFS data available. (Please note that throughout this document, the terms "benchmark" and "county rate" are used interchangeably, and the term "service area benchmark" indicates the bidding target for an MA plan based on its specific service area.) Section 1853(n)(4) requires that the benchmark for an area for a year (including increases for quality bonus percentages) be capped at the level of the applicable amount, as defined at section 1853(k)(1).

PACE payment rates are not developed using the specified amount, per section 1853(n)(5) of the Act, but are developed using the applicable amount, as defined at section 1853(k)(1), as discussed below.

A1. Applicable Amount

The applicable amount is the rate established under section 1853(k)(1) of the Act. As CMS intends to rebase the rates in 2025, the applicable amount for 2025 is the greater of: (1) the county's 2025 FFS cost (that is, the 2025 FFS USPCC adjusted for the county) or (2) the 2024 applicable amount increased by the CY 2025 National Per Capita Medicare Advantage Growth Percentage. As discussed in Section A5, section 1853(n)(4) of the Act requires that the benchmark (determined taking into account the application of the quality bonus payment (QBP) percentage) for each county must be capped at the county's applicable amount.

A2. Specified Amount

Under section 1853(n)(2)(A) of the Act, the specified amount is based upon the following formula:

(2025 FFS cost minus (IME phase-out amount and kidney acquisition costs)) × (applicable percentage + applicable percentage quality increase)

Where:

FFS cost is the FFS per capita cost for the area for the year, adjusted to exclude costs attributable to payments under sections 1848(o), 1886(n), and 1886(h), as described in more detail below in Section B;

IME phase-out amount is the amount of indirect costs of medical education that is required to be phased out as specified at section 1853(k)(4) and section 1853(n)(2)(A)(i) and (F);

Kidney acquisition costs are the standardized costs for payments for organ acquisitions for kidney transplants that are required to be excluded, beginning 2021, as specified at section 1853(k)(5) and section 1853(n)(2)(A)(i) and (G);

Applicable percentage is a statutory percentage applied to the county's base payment amount, as described at section 1853(n)(2)(B); and

Applicable percentage quality increase, referred to in this document as the QBP percentage, is a percentage point increase to the applicable percentage for a county in a qualifying plan's service area as provided in section 1853(o).

Section 1853(n)(2)(B) and (C) of the Act requires CMS to determine applicable percentages for a year based on county FFS rate rankings for the most recent year that was a rebasing year. To determine the CY 2025 applicable percentages for counties in the 50 States and the District of Columbia, CMS ranks counties from highest to lowest based upon their 2024 average per capita FFS rate adjusted to exclude the IME phase out and payments for kidney acquisition for transplant. The 2024 rates are used because 2024 is the most recent rebasing year prior to 2025. CMS then places the rates into four quartiles. For the territories, CMS assigns an applicable percentage to each territory county based on where the territory county rate falls in the quartiles established for the 50 States and the District of Columbia.

CMS is publishing the 2025 applicable percentages by county with the Advance Notice at https://www.cms.gov/Medicare/Health-Plans/MedicareAdvtgSpecRateStats/Announcements-and-Documents.html. Each county's applicable percentage is assigned based upon its quartile ranking, as follows:

Table II-1. FFS Quartile Assignment

Quartile	Applicable Percentage
4th (highest)	95%
3rd	100%
2nd	107.5%
1st (lowest)	115%

Section 1853(n)(2)(D) of the Act provides that, beginning in 2013, if there is a change in a county's quartile ranking for a payment year compared to the county's ranking in the previous year, the applicable percentage for the area for the year shall be the average of: (1) the applicable percentage for the previous year and (2) the applicable percentage for the current year. For both years, CMS calculates the applicable percentage that would otherwise apply for the area for the year in the absence of this transitional provision. For example, if a county's ranking changed from the second quartile to the third quartile, the applicable percentage would be 103.75 percent for the year of the change – the average of 107.5 percent and 100 percent (see Table II-1 above).

A3. Quality Bonus Payment Percentage

The Act provides for CMS to make quality bonus payments to MA organizations that meet quality standards measured under a five-star quality rating system. In this document, we refer to this quality bonus as the *QBP percentage* instead of using the statutory term *applicable percentage quality increase*. The QBP percentage is a percentage point increase to the applicable percentage for each county in a qualifying plan's service area, before multiplying the percentage by the FFS rate for the year to determine the specified amount.

Table II-2 shows the QBP percentage for each Star Rating. Plans with fewer than four stars will not receive a QBP percentage increase to the county rates and plans with four or more stars will receive a QBP percentage increase in the calculation of the county rates, as set forth in sections 1853(n) and 1853(o) of the Act. See Section A6 for rebate percentages.

Table II-2. Percentage Add-on to Applicable Percentage for Quality Bonus Payments

Star Rating	QBP Percentage
Fewer than 4 stars	0%
4, 4.5, and 5 stars	5%

An MA plan's Star Rating is the rating assigned to its contract applying the 5-star rating system (based on the data collected under section 1852(e) of the Act) specified in §§ 422.160 through 422.166.[14] The contract rating is applied to each plan under that contract. MA plans with a Star Rating of four or more stars will bid against their service area benchmarks that include the 5-percentage point QBP add-on to the applicable percentage for the benchmark in each county in the service area. MA plans with a Star Rating of fewer than four stars will bid against service area benchmarks that do not include QBP add-ons to the county rates, with the exceptions of new MA plans and low enrollment plans. As discussed below, all benchmarks (determined after application of the QBP percentage) are capped at the section 1853(k)(1) applicable amount per section 1853(n)(4) of the Act.

New MA Plans

New MA plans are treated as qualifying plans that are eligible to receive a QBP percentage increase to the county rates, except that the QBP percentage will be 3.5 percentage points, per section 1853(o)(3)(A)(iii)(I)(cc) of the Act and §§ 422.166(d)(2)(v) and 422.258(d)(7)(v)(C). That is, new MA plans will bid against a service area benchmark that reflects a 3.5 percentage point increase to the applicable percentage used to set the benchmark for each county in the plan's service area. Per section 1853(o)(3)(A)(iii)(II) of the Act and § 422.252, for the purpose of determining a QBP percentage, the term "new MA plan" refers to an MA plan offered by a parent organization that has not had another MA contract in the preceding three-year period.

Per § 422.166(d)(2)(vi), for a parent organization that has had a contract with CMS in the preceding three-year-period, any new MA contract (and MA plans under that contract) under that parent organization will receive an enrollment-weighted average of the Star Ratings earned by the parent organization's existing MA contracts.

Low Enrollment Plans

Low enrollment plans do not receive a quality Star Rating under the 5-star rating system (specified in §§ 422.160 through 422.166) but are treated as qualifying plans for purposes of the QBP. *See* 42 CFR §§ 422.166(d)(2)(v) and 422.258(d)(7)(iv). Section 1853(o)(3)(A)(ii)(II) of

[14] All regulatory cites are to Title 42 of the Code of Federal Regulations unless otherwise noted.

the Act, as implemented at § 422.258(d)(7)(iv)(B), provides that for 2013 and subsequent years, CMS shall develop a method for determining whether an MA plan with low enrollment is a qualifying plan for purposes of receiving an increase in payment under section 1853(o). We apply this determination at the contract level, and thus determine whether a contract (meaning all plans under that contract) is a qualifying contract. Pursuant to § 422.252, a low enrollment contract is one that could not undertake Healthcare Effectiveness Data and Information Set (HEDIS) and Health Outcome Survey (HOS) data collections because of a lack of a sufficient number of enrollees (that is, fewer than 500 enrollees) to reliably measure the performance of the health plan.

Section 1853(o)(3)(A)(ii) of the Act does not address the amount of the increase for low enrollment contracts. We intend to continue the current policy that low enrollment contracts be included as qualifying contracts that receive the QBP percentage of 3.5 percentage points, similar to the QBP percentage increase applied to new MA plans. We discussed the basis of this policy in detail in the 2018 Advance Notice (pages 12-13) (https://www.cms.gov/Medicare/Health-Plans/MedicareAdvtgSpecRateStats/Downloads/Advance2018.pdf).

Contract Consolidations and QBP

Section 1853(o)(4) of the Act was amended by the Bipartisan Budget Act of 2018 to add subsection (D) regarding the determination of Star Ratings for consolidating MA plans, which is implemented for MA plans at § 422.162(b)(3) for contract consolidations approved on or after January 1, 2019. When two or more contracts for health and/or drug services of the same plan type under the same legal entity are combined into a single contract at the start of a contract year, the rating used to determine QBP status ("QBP rating") for the first year following the consolidation will be the enrollment weighted average of what would have been the QBP ratings of the surviving and consumed contracts, using the contract enrollment in November of the year the Star Ratings were released (§ 422.162(b)(3)(ii)). For the second year after consolidation, CMS will determine QBP status based on the consolidated contract's Star Ratings displayed on Medicare Plan Finder, which will be calculated as provided in § 422.162(b)(3)(iv)(B).

A4. Qualifying County Bonus Payment

Beginning with contract year 2012, pursuant to section 1853(o)(2) of the Act and § 422.258(d)(7)(ii), the QBP percentage is doubled for a qualifying plan located in a "qualifying county." A qualifying county is a county that meets the following three criteria:

(1) has an MA capitation rate that, in 2004, was based on the amount specified in section 1853(c)(1)(B) for a Metropolitan Statistical Area with a population of more than 250,000;

(2) as of December 2009, had at least 25 percent of MA-eligible beneficiaries residing in the county enrolled in a MA plan; and

(3) has per capita FFS County spending for the year (2025) that is less than the national monthly per capita cost for FFS for the year (2025).

See section 1853(o)(3)(B) of the Act and § 422.258(d)(7)(ii).

Example: As described in Section A3, a plan with a rating of 4.5 stars will have 5 QBP percentage points added to the applicable percentage of each county in its service area. For each county that meets the three criteria stated above in that plan's service area, that percentage will be doubled so that an additional 5 percentage points will be added to that county's applicable percentage for a total increase of 10 percentage points. If this qualifying county otherwise has an applicable percentage of 95 percent, this is increased to 105 percent to reflect the quality bonus payment percentage for that county. As discussed in Section A5 below, all benchmarks are capped at the section 1853(k)(1) applicable amount (determined after application of the QBP percentage) per section 1853(n)(4) of the Act.

CMS will publish a complete list of qualifying counties with the final 2025 Rate Announcement. The listing will contain all counties that meet all three criteria stated above. Two of the three elements for determining a qualifying county (2004 urban floors (Y/N) for each county, and 2009 Medicare Advantage penetration rates) can be found in the 2024 Rate Calculation Data file (columns AB and AD) on the CMS website at https://www.cms.gov/Medicare/Health-Plans/MedicareAdvtgSpecRateStats/Ratebooks-and-Supporting-Data.html. The 2025 FFS rates, which are necessary for the third criterion, are not available at the time this Advance Notice is published. The FFS rates and the national average FFS spending amount will be published in the final 2025 Rate Announcement.

A5. Cap on Benchmarks

Section 1853(n)(4) of the Act requires that the benchmark (determined by taking into account the application of the QBP percentage) for a county must be capped at the level of the county's applicable amount determined under section 1853(k)(1). This provision requires that the QBP increase be included in the benchmark before the comparison is made to determine if the cap is applied. Thus, for all counties, post-QBP percentage rates are capped at the section 1853(k)(1) applicable amount.

While we appreciate the concerns stakeholders have raised in connection with the cap on benchmarks, CMS believes that section 1853(n)(4) of the Act prevents elimination of the cap or excluding the bonus payment from the cap calculation.

A6. Rebate

Under section 1854(b)(1)(C)(v) of the Act, except for Medical Savings Account (MSA) plans, the level of rebate for each plan is based on the plan's Star Rating. Rebates for each plan are calculated as a percentage of the amount by which the risk-adjusted service area benchmark exceeds the risk-adjusted bid. Under § 422.266(b), plans may use rebates to pay for mandatory supplemental benefits and/or to buy down beneficiary premiums for Part B and/or Part D prescription drug coverage. Pursuant to section 1854(b)(1)(C)(v), which is implemented in § 422.266(a)(2)(ii), the rebate percentages apply based on a plan's Star Rating, as shown in Table II-3.

Table II-3. MA Rebate Percentages

Star Rating	Rebate Percentage
4.5+ Stars	70%
3.5 to < 4.5 stars	65%
< 3.5 stars	50%

Section 1854(b)(1)(C)(vi)(II) of the Act requires that, for purposes of determining the rebate percentage, a new MA contract under a new parent organization will be treated as having a Star Rating of 3.5 stars for 2012 and subsequent years. *See* also § 422.266(a)(2)(iv). The statute is silent on the rebate percentage to assign to low enrollment plans in years after 2012. We view this as a gap in the statute, particularly in light of the direction in section 1853(o)(3)(A)(ii) to treat low enrollment plans as qualifying plans for purposes of the QBP percentage. As we have in prior years, CMS intends to treat low enrollment plans as having a Star Rating of 3.5 stars for purposes of determining the rebate percentage, therefore rebates for each low enrollment plan are calculated as 65% of the amount by which the risk-adjusted service area benchmark exceeds the risk-adjusted bid.

Section B. Calculation of Fee for Service Cost

B1. Introduction

The FFS per capita cost for each county is the product of (1) the national FFS per capita cost, or United States per-capita cost (USPCC), and (2) a county-level geographic index called the average geographic adjustment (AGA). Each year, CMS strives to improve the development of the AGAs and estimated FFS per capita costs with refinements to how these figures are calculated.

We will continue to incorporate refinements developed and used in prior years to update the claims data used to calculate the AGAs and to continue the repricing of historical data in the AGA calculation to reflect changes in FFS payment rules. CMS will reprice historical hospital inpatient, hospital outpatient, skilled nursing facility, and home health claims to reflect the most currently available wage indices, and re-tabulate physician claims with the most currently available Geographic Practice Cost Index. We will also reprice historical claims to account for legislative and regulatory changes made to uncompensated care payments. Repricing historical claims used for the AGAs, in conjunction with rebasing rates, ensures that the FFS rates for each county reflect the most current FFS fee schedules and payment rules.

We will continue a refinement to the methodology used in the ratebook development to include Health Professional Shortage Areas (HPSAs) bonus payments. Specifically, we will tabulate the HPSA bonuses by county of residence for years 2018–2022 and add these values to our ratebook FFS expenditures. The HPSA bonuses are disbursed quarterly to providers and are not reflected in the standard claim files.

With this Advance Notice, we are releasing the 2022 FFS cost data by county used 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. These data do not reflect adjustments for Innovation Center models and demonstrations and the Medicare Shared Savings Program and Advanced Alternative Payment Models, and do not reflect adjustments for claim repricing for the most current available Medicare FFS payment final rules and parameters.

B2. AGA Methodology

In the first step of the AGA methodology, CMS will add the 2022 cost and enrollment data to, and drop the 2017 cost and enrollment data from, the historical claims experience used to develop new geographic cost indices for each county. As a result, the five-year rolling average will be based on non-hospice Medicare FFS claims data from 2018-2022. CMS will then perform a series of adjustments to the historical Medicare FFS data to estimate FFS rates per county, explained below as successive steps.

For Puerto Rico, CMS will continue to include five years (2018-2022) of historical claims and enrollment only for beneficiaries with Part A and Part B enrollment at the time of the dates of service for the FFS claim. 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. CMS continues to believe it is appropriate to adjust the FFS rate calculation in Puerto Rico used to determine MA rates so that it is based on beneficiaries who are enrolled in both Part A and Part B in order to produce a more accurate projection of FFS costs per capita in Puerto Rico.

In the second step, CMS will reprice the historical inpatient, hospital outpatient, skilled nursing facility, and home health claims from 2018-2022 to reflect the most current (i.e., FY 2024) wage indices, re-tabulate physician claims with the most current Geographic Practice Cost Indices, and reprice Medicare Durable Medical Equipment, Prosthetics, Orthotics, and Supplies (DMEPOS) claims in accordance with the payment rules in effect during the temporary gap period for the DMEPOS Competitive Bidding Program[15] starting January 1, 2024. In former competitive bidding areas (CBAs), adjusted fees are based on the single payment amounts updated by the projected percentage change in the CPI-U from January 2023 to January 2024. In non-CBAs, the adjusted fees are based on fully adjusted rates per the applicable methodology under 42 CFR 414.210(g). The January 2024 fee schedules for repricing DMEPOS claims are accessible on the CMS website at: https://www.cms.gov/Medicare/MedicareFeeforServicePayment/DMEPOSFeeSched/DMEPOS-Fee-Schedule.

As noted on page 35 of the CY 2022 Rate Announcement[16], and consistent with prior years, we do not propose to reprice Part B drugs and we have not developed the data and systems to support such repricing. Therefore, we would not reprice Part B drugs as part of our adjustments to the AGAs irrespective of the 340B remedy rule provision for lump sum remedy payments for services rendered from January 1, 2018 through September 27, 2022 for each 340B covered entity. On September 28, 2022, the District Court for the District of Columbia vacated the differential payment rates for 340B-acquired drugs going forward. As a result, all CY 2022 claims for 340B-acquired drugs paid on or after September 28, 2022, were paid at the default rate (generally ASP plus 6%). As such, many CY 2022 340B drug claims have been processed, or reprocessed through standard claims processing procedures, at the higher 340B payment rate (generally ASP plus 6%) as described in the Hospital Outpatient Prospective Payment System Remedy for the 340B-Acquired Drug Payment Policy for Calendar Years 2018-2022 Final Rule, CMS-1793-F, (88 FR 77150–94), issued on November 2, 2023. The processing, or reprocessing through standard claims processing procedures, at the higher 340B payment rate (generally ASP plus 6%) for these aforementioned CY 2022 claims will be included in 2022 FFS experience supporting the ratebook AGAs.

We will continue to adjust the uncompensated care payments (UCP) represented in the 2018–2022 claims to reflect the requirements of the most recent final rule (here, the FY 2024 Inpatient Prospective Payment System (IPPS) final rule). The repricing will include the supplemental payment for certain hospitals in Puerto Rico and certain Indian Health Service / Tribal hospitals that was adopted in the FY 2023 IPPS final rule. Repricing for Puerto Rico inpatient claims will

[15] For more information on the DMEPOS Competitive Bidding Program Temporary Gap Period, please see: https://www.cms.gov/files/document/mln764994-dmepos-competitive-bidding-program-temporary-gap-period.pdf

[16] https://www.cms.gov/files/document/2022-announcement.pdf

continue to reflect the Consolidated Appropriations Act, 2016 (Pub. L. 114-113, Division O, section 601), which amended section 1886(d)(9)(E) of the Act.

We will continue to use, as the source of the county designation of beneficiaries used in the summarization of the risk scores, the county assignment used for the ratebook FFS claims and enrollment. For contract years 2016 and earlier, the county assignment for each FFS beneficiary was based on the ZIP code associated with the beneficiary's mailing address. Beginning with the 2017 ratebook, we used the county of residence provided by the Social Security Administration, which is the same county assignment as the ratebook FFS claims and enrollment.

The statutory component of the Regional MA benchmarks for RPPOs will also continue to be based on this county designation of beneficiaries. Under our implementation of section 1858(f)(2) of the Act, the standardized RPPO benchmark for each MA region includes a statutory component consisting of the weighted average of the county capitation rates across the region for each appropriate level of Star Rating. The enrollment weights for the statutory component will reflect this county designation of beneficiaries.

As in prior years, (1) CMS will make additional adjustments to the FFS costs described below, and (2) the average of each county's five-year geographic indices, based on the adjusted claims data, will be divided by the county's average five-year risk score in order to develop the AGA for that county. Consistent with the development of prior years' ratebooks, the risk scores used to standardize the non-ESRD and ESRD ratebooks will be based on the risk adjustment model(s) and risk adjustment policies used for the applicable contract year (2025) payment.

B3. Adjustments for Medicare Shared Savings Program and Innovation Center Models and Demonstrations, and Advanced Alternative Payment Models

Medicare Shared Savings Program and Innovation Center Models and Demonstrations

As indicated in Table II-4, we will continue to adjust historical FFS experience to incorporate shared savings and losses or episode savings and losses experienced under the Medicare Shared Savings Program and Innovation Center models and demonstrations. We will update the experience years used for this adjustment as noted on Table II-4. All adjustments of this type apply to only the non-ESRD ratebook except the model(s) noted as ESRD in Table II-4.

Table II-4. The Medicare Shared Savings Program and Innovation Center Models and Demonstrations with Ratebook Adjustments

Program/Models and Demonstrations	Experience Years		Payment Type
	2024 Ratebook	2025 Ratebook	
Medicare Shared Savings Program	2017-2021	2018-2022	Shared savings / shared losses
Comprehensive Care for Joint Replacement (CJR)	2017-2021	2018-2021	Episode savings / episode losses
Next Generation ACO (NGACO)	2017-2021	2018-2021	Shared savings / shared losses
Oncology Care Model (OCM)	2017-2021	2018-2022	Episode savings / episode losses
Bundled Payments for Care Improvement (BPCI)	2017-2018	2018	Episode savings / episode losses
Bundled Payment for Care Improvement Advanced (BPCI Advanced)	10/1/2018-2021	10/1/2018-2022	Episode savings / episode losses
Medicare-Medicaid Financial Alignment Initiative Managed FFS Model	2017-2020	2018-2020	Shared savings
Vermont Medicare ACO Initiative	2018-2021	2018-2022	Shared Savings / shared losses
Maryland Primary Care Program	2019-2020	2019-2022	Performance-based Incentive Payment
Global and Professional Direct Contracting / ACO Realizing Equity, Access, and Community Health (GPDC/ACO REACH)	2021 (began 4/1)	4/1/2021-2022	Shared savings / shared losses
Next Generation ACO (NGACO)	2017-2021	2018-2021	Population-based payment
Vermont Medicare ACO Initiative	2018-2021	2018-2022	Population-based payment
Maryland Primary Care Program	2019-2021	2019-2022	Population-based payment
Primary Care First	2021	2021-2022	Population-based payment
Primary Care First	N/A	2022	Performance-based Incentive Payment
Global and Professional Direct Contracting / ACO Realizing Equity,	2021 (began 4/1)	4/1/2021-2022	Population-based payment

Program/Models and Demonstrations	Experience Years		Payment Type
	2024 Ratebook	2025 Ratebook	
Access, and Community Health (GPDC/REACH)			
Comprehensive Primary Care Plus (CPC+)	2017-2021	2018-2021	Comprehensive Primary Care Payments
Comprehensive Primary Care Plus (CPC+)	2017-2021	2018-2021	Performance-based Incentive Payment
Comprehensive Primary Care Plus (CPC+)	2017-2021	2018-2021	Care Management Fees
Maryland Primary Care Program	2019-2021	2019-2022	Care Management Fees
Kidney Care Choices / Comprehensive Kidney Care Contracting Option	N/A	2022	Population-based payment
ESRD			
Comprehensive ESRD Care (CEC)	2017-3/31/2021	2018-3/31/2021	Shared savings / shared losses
Next Gen ACO (NGACO)	2017-2021	2018-2021	Population-based payment
Vermont Medicare ACO Initiative	2018-2021	2018-2022	Population-based payment
Global and Professional Direct Contracting / ACO Realizing Equity, Access, and Community Health (GPDC/REACH)	2021 (began 4/1)	4/1/2021-2022	Population-based payment

Notes on the table above:

- 2018 shared savings payments for "Vermont Medicare Accountable Care Organization (ACO) Initiative" are included with Next Generation ACO
- In the 2021 Rate Announcement, "Vermont Medicare ACO Initiative" was labeled "Vermont All-Payer ACO", and payments were not actually made in 2017 but began in 2018 and were reported under the program "Next Generation ACO."
- Comprehensive ESRD Care (CEC) shared saving / shared losses for both 2024 and 2025 ratebooks include experience through the end of the model, March 31, 2021

The key aspects of these adjustments are:

- The adjustments reflect an allocation of the savings and losses based on the distribution of the participating entity's aligned beneficiaries by county of residence. The adjustments

applied to the non-ESRD ratebook exclude experience for beneficiaries in ESRD status as of July 1 of the experience year. (The adjustments for the model(s) noted as ESRD in Table II-4, which are applied to the ESRD ratebook in a similar manner as the non-ESRD cohort, include experience for beneficiaries in ESRD status.)

- Under the models noted as using "population-based payments" in Table II-4, participants receive a monthly fee that ultimately offsets a percentage reduction in FFS payments to certain providers and suppliers aligned with participants over the same year. For each affected claim, the reduction amount represents the portion of the payment that has effectively been rerouted to the ACO via the population-based payment and is therefore added back to the reduced FFS amount so that the total reimbursement amount is represented.
- Under the CPC+ models, participants receive quarterly payments that replace a percentage of FFS claim amounts for each affected claim. The "comprehensive primary care payments" are included with claim costs to compile the total reimbursement amount.
- In the ratebooks for contract years 2020 and earlier, the allocation of the Medicare Shared Savings Program and Innovation Center model and demonstration payment adjustments between the Part A and Part B Trust Funds was based on the Part A and Part B proportion of the FFS USPCC for each calendar year. Consistent with the actual payments by the Trust Fund, we intend to continue with the approach started for CY 2021 ratebook to allocate the entire amount of the following payments for all experience years to the Part B Trust Fund: (i) Oncology Care Model episode savings / losses, (ii) Comprehensive Primary Care Plus comprehensive primary care payments, performance-based incentive payments, and care management fees, (iii) Maryland Primary Care Program care management fees and population-based payments, and (iv) Primary Care First population-based payments and performance-based incentive payments. The remaining Medicare Shared Savings Program and Innovation Center model and demonstration payment adjustments will continue to be allocated in the MA ratebook calculations between the Part A and Part B Trust Funds based on the Part A and Part B proportion of the FFS USPCC for each calendar year.

Further information on the Medicare Shared Savings Program may be found at: https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/sharedsavingsprogram. Further information on the Innovation Center models and demonstrations may be found at: https://innovation.cms.gov/.

Although we considered whether to adjust the FFS claims experience for care management fees, per-beneficiary-per-month fees, and/or advance payment of shared savings paid to providers for

other Innovation Center models conducted in 2018-2022 period,[17] we intend to continue prior policy and will not take fees of this type into account in our adjustments to historical FFS experience when such fees or payments were not funded from Medicare Parts A or B Trust Funds.

Advanced Alternative Payment Models

Section 1833(z)(1) of the Act requires payment of an incentive for physicians and other eligible clinicians who become qualifying APM participants (QPs) through sufficient participation in an Advanced Alternative Payment Model (A-APM) for payment years from 2019 through 2024.

A-APMs can include: 1) models under section 1115A of the Act (other than a health care innovation award), 2) certain two-sided models under the Shared Savings Program under section 1899 of the Act, 3) demonstrations under section 1866C of the Act, and 4) demonstrations required by federal law when these alternative payment models meet the criteria specified in § 414.1415, including requiring the use of Certified Electronic Health Record Technology (CEHRT), making payment based on quality measures, and requiring assumption of a more than nominal amount of financial risk. The QP performance period occurs two years prior to payment of the APM incentive. QPs determinations are made for each eligible clinician at the Taxpayer Identification Number (TIN) / National Provider Identifier (NPI) level. The first QP performance year was 2017, and the first APM incentive payments were made to QPs in 2019.

APM incentive payments are calculated and paid as specified in § 414.1450. The amount of the APM incentive payment for payment years 2019 through 2024 is equal to 5 percent, and for 2025 is equal to 3.5 percent, of the QP's estimated aggregate payments for covered professional services as defined in 1848(k)(3)(A) of the Act furnished during a base year which is the calendar year immediately preceding the payment year. Base year estimated aggregate payments and the corresponding APM incentive payment are calculated for each QP using all of their TIN/NPI combinations.

The applicable periods for APM incentive payments made to date are:

Table II-5. Applicable Periods for APM Incentive Payments

QP performance year	2017	2018	2019	2020	2021
Base year	2018	2019	2020	2021	2022
Payment year	2019	2020	2021	2022	2023

[17] Information about the various Innovation Center models is available in the Report to Congress available at: https://innovation.cms.gov/data-and-reports/2021/rtc-2020

We are proposing to include with the ratebook historical experience the APM incentive payments disbursed in years 2019 through 2022. The APM incentive payments will be added to ratebook FFS experience for the payment year. For example, the APM incentive payments made in 2019 will be added to 2019 ratebook FFS experience. The APM incentive payment adjustment will be allocated based on the distribution of claim expenditures by county of beneficiary residence for the base year expenditures for each TIN/NPI. Excluded from the adjustment will be the small proportion, less than 0.50 percent, of incentive payments for providers with no base period experience, given there is no basis for allocation of payments by beneficiary residence for such providers. The adjustment will apply to both non-ESRD and dialysis populations.

Further information on the Advanced Alternative Payment Models may be found at: https://qpp.cms.gov/apms/advanced-apms.

B4. Additional Adjustment to FFS per Capita Costs in Puerto Rico

For the past eight years, the Secretary has directed the Office of the Actuary to adjust the FFS experience for beneficiaries enrolled in Puerto Rico to reflect the nationwide propensity of beneficiaries with zero claims. For the CY 2017–2024 Rate Announcements, the Office of the Actuary evaluated experience exclusively for beneficiaries who were enrolled in both Parts A and B ("A&B beneficiaries") and were not dually eligible for Veterans Affairs (VA) coverage. The study for setting the CY 2024 rates analyzed experience for calendar years 2017 through 2021 and only considered FFS beneficiaries enrolled mid-year. On average over this period, 14.5 percent of A&B Puerto Rico FFS beneficiaries were found to have no Medicare Part A or Part B claim reimbursements per year. This compares to a nationwide non-territory proportion of 6.1 percent of A&B FFS beneficiaries found to have no Medicare Part A claim reimbursements and no Medicare Part B claim reimbursements per year over the same period. Based on the Secretary's direction, the Puerto Rico FFS weighting of enrollment and risk scores for the zero-claim cohort was adjusted to reflect the nationwide proportion of zero-claim beneficiaries. The resulting impact was measured as an average increase in the standardized per-capita FFS costs in Puerto Rico of 4.4 percent for 2017 through 2021. Accordingly, a 4.4 percent adjustment was then applied to the pre-standardized Puerto Rico FFS rates supporting the CY 2024 ratebook development.

We are considering whether a similar adjustment should be applied for 2025. The Office of the Actuary will perform an analysis that is similar to the prior analysis but with an updated five years of data: 2018-2022. We welcome comments regarding a similar update to Puerto Rico's experience in the development of the 2025 FFS rates. We will review the results of this study and any comments that we receive, and we will specify in the final Rate Announcement any adjustment that we determine may be necessary based on those results and comments.

Concerns have been raised in the past by stakeholders regarding the FFS data used to establish MA benchmarks in Puerto Rico. As discussed in the CY 2017 Advance Notice, the law requires that MA benchmarks be based on a county's average Medicare FFS per-capita cost, 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. As we stated originally in the CY 2017 Rate Announcement and in Rate Announcements for several years since, our actuarial analyses have indicated that the FFS data in Puerto Rico is sufficient for establishing accurate MA benchmarks.

We also seek comment on alternate adjustment approaches that may be appropriate in Puerto Rico.

B5. Additional Adjustments

The following adjustments are made after the AGA is calculated:

- Direct Graduate Medical Education: removed from FFS county costs (as directed by section 1853(c)(1)(D)(i) of the Act), described in more detail in Section C1.
- Credibility: for counties with fewer than 1,000 members, blend county experience with that of others in the market area.
- VA and Department of Defense (DoD): apply an adjustment to FFS per capita costs for beneficiaries dually enrolled in VA and/or the DoD health programs (the Uniformed Services Family Health Plan (USFHP) and/or the Veterans Health Administration (VHA)) pursuant to section 1853(c)(1)(D)(iii) of the Act. The VA/DoD adjustment for the 2025 rates will be based upon an updated study that uses FFS data from calendar years 2017-2021. The methodology for the study and adjustment is described in more detail in the CY 2022 Advance Notice Part II (pages 27-28).
- Organ Acquisition Costs for Kidney Transplants: removed from FFS costs, described in more detail in Section C2.
- Indirect Medical Education: removed from FFS county costs (section 1853(n)(2)(F) of the Act) as described in more detail in Section C3.

Note that incentive payments for adoption and meaningful use of certified electronic health record (EHR) technology are not included in the claims used to develop the FFS costs and therefore no explicit adjustment is needed to exclude these payments from the FFS costs to comply with section 1853(c)(1)(D) of the Act.

Section C. Adjustments to the AGAs

Section C1. Direct Graduate Medical Education

See Attachment I Section A regarding medical education expenses in USPCCs.

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 Medicare Advantage ratebooks.

Please note that some ratebook files and other CMS data reference "graduate medical expenses," or GME. In the context of the MA ratebooks, DGME and GME refer to the same item and are used interchangeably.

The steps involved in the calculation of the DGME carve-out for CY 2025 for non-Maryland facilities are the same as used for CY 2024 and are as follows:

a. Identify on the Medicare cost reports (Form CMS-2552-10) those expenditures to be excluded from the MA ratebooks (that is, those costs on the report that are attributable to payments made under section 1886(h)):
    1. Part A DGME: Cost report worksheet E-4, line 49, column 1
    2. Part B DGME: Cost report worksheet E-4, line 50, column 1

b. Identify cost report fields reflected on the Direct Medical Education per diem field on the Provider Specific File (PSF) for each Provider State based on the jurisdiction of each Medicare Administrative Contractor (MAC). This data is available on the CMS website at: https://www.cms.gov/Medicare/Health-Plans/MedicareAdvtgSpecRateStats/Announcements-and-Documents. The two-digit state code corresponds to the first two digits of the inpatient provider ID.

c. Using the information from "a" and "b", tabulate for each provider and calendar year:
    1. Expenditures to be removed from MA rates (item a)
    2. Expenditures represented in DGME field in provider specific file (item b)
    3. Proportion of DGME PSF values to be excluded from rates (c1 / c2)

d. Accumulate DGME PSF values by county and calendar year:
    1. Multiply the DGME per diem amount on PSF times the number of covered days for each inpatient admission from the FFS claims files.
    2. Accumulate d1 by county of beneficiary residence

e. Calculate DGME exclusion for each county and calendar year: d2 × c3

We are proposing to revise the data and methodology used to develop the DGME carveout for hospitals participating in the Maryland Total Cost of Care (TCOC) Model.

The 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 the Inpatient Prospective Payment System (IPPS) and the Outpatient Prospective Payment System (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 Heath Services Cost Review Commission (HSCRC) to identify data that can be used to develop the DGME and IME carve-outs for hospitals participating in the Maryland TCOC Model.

The proposed adjustment will be based on the Provider Statistical & Reimbursement Report (PS&R) figures for Medicare Advantage (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 expenditures and MA days of admission, which are used to calculate the DGME per diem for MA admissions. This MA experience is used as the basis for the FFS DGME amounts since DGME payments for FFS admissions are not included in the inpatient Provider Specific File for providers participating in the Maryland TCOC model.

The proposed adjustment is as follows:

1. Calculate average per diem DGME amount for each TCOC facility and corresponding fiscal year (FY) ending in June as: DGME amount from the PS&R divided by days of admission from the PS&R.
    a. Actual PS&Rs and DGME experience are available through FY 2022. The DGME amounts are represented in the "From Intermediary Total IME & DME Payments" field on the Calculation of Medicare GME Discounts spreadsheets on HSCRC's Policy Clarifications and Regulations Updates web page.[18]
    b. Estimated DGME per diem amounts for each facility for FY 2023 to be calculated as FY 2022 per diem amount multiplied by (1 + HSCRC's Proposed Inflation Update[19] for rate year 2023) or (1 + 0.046).
2. DGME for each FFS claim in the NCH is tabulated as: per diem from step 1 applicable to facility and date of admission multiplied by number of covered days for each inpatient admission. This tabulation only applies to providers participating in the TCOC model.

[18] https://hscrc.maryland.gov/Pages/pdr_clarifications.aspx

[19] Table 1, HSCRC's Final Recommendation for the Update Factors for Rate Year 2023, available from website: https://hscrc.maryland.gov/Documents/RY23FinalUFRecommendation_approved.pdf

3. Amounts from step 2 are accumulated by county of beneficiary residence.

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

Section C2. Organ Acquisition Costs for Kidney Transplants

Section 17006(b) of the 21st Century Cures Act amended section 1853(k) and (n) of the Act to exclude CMS's estimate of the standardized costs for payments for organ acquisition for kidney transplants from MA benchmarks starting in 2021. Section 1853(k)(5) of the Act, implemented in § 422.306(d), provides for the exclusion of these costs from the applicable amount and section 1853(n)(2)(A)(i), implemented in § 422.258(d), provides for the exclusion from the base amount (used to calculate the specified amount). Further, section 17006(c) of the 21st Century Cures Act amended sections 1851(i) and 1852(a)(1)(B); the amendments, implemented[20] in § 422.100(c)(1) and § 422.322, require FFS coverage of organ acquisition costs for kidney transplants incurred by MA enrollees and exclude coverage of organ acquisitions for kidney transplants from the benefits that MA plans must provide to their enrollees. As discussed in the CY 2021 final rule (CMS-4190-F) (85 FR 33825) and 2021 Advance Notice, we apply the carve-out from the FFS costs when developing ESRD MA rates as well.

The 21st Century Cures Act did not require Medicare FFS coverage of organ acquisition costs for kidney transplants received by PACE participants. Therefore, as noted in the CY 2021 final rule (85 FR 33824–25), PACE organizations must continue to cover organ acquisition costs for kidney transplants consistent with the requirement in section 1894(b)(1)(A)(i) of the Act that PACE organizations provide all Medicare-covered items and services. Accordingly, CMS will continue to include the costs for kidney acquisitions in PACE payment rates–both the PACE county rates and the PACE ESRD rates–unlike for MA benchmarks.

The steps involved in the calculation of the Kidney Acquisition Cost (KAC) carve-out for CY 2025 are the same as used for CY 2024 and are as follows:

a. Identify on the Medicare Cost Reports (Form CMS-2552-10) those expenditures that are related to organ acquisition costs. This will be used in the next step to calculate the proportion of organ acquisition costs that represents kidney acquisition costs (that is, the proportion of costs on the report that is attributable to payments made under section 1881(d) of the Act), which is to be excluded from the MA ratebooks:
    1. Cost report worksheet D-4 (Heart), line 69, column 1
    2. Cost report worksheet D-4 (Intestine), line 69, column 1
    3. Cost report worksheet D-4 (Islet), line 69, column 1

[20] See the CY 2021 final rule (CMS-4190-F) (85 FR 33796, 33824–26) titled "Medicare Program; Contract Year 2021 Policy and Technical Changes to the Medicare Advantage Program, Medicare Prescription Drug Benefit Program, and Medicare Cost Plan Program."

4. Cost report worksheet D-4 (Kidney), line 69, column 1
5. Cost report worksheet D-4 (Liver), line 69, column 1
6. Cost report worksheet D-4 (Lung), line 69, column 1
7. Cost report worksheet D-4 (Pancreas), line 69, column 1

b. Using information from "a", tabulate for each provider and calendar year the proportion of organ acquisition costs[21] that are applicable to kidneys: a4 / (a1 + a2 + a3 + a4 + a5 + a6 + a7).

c. Identify the Organ Acquisition Cost (OAC) per diem field on the inpatient Provider Specific File (PSF) for each Provider State based on each MAC's jurisdiction (this data is available on the CMS website at: https://www.cms.gov/Medicare/Health-Plans/MedicareAdvtgSpecRateStats/Announcements-and-Documents) and date of admission. The two-digit state code corresponds to the first two digits of the inpatient provider ID.

d. Accumulate KAC PSF values by county and calendar year:
    1. Calculate the per admission KAC carveout as the OAC per diem amount on PSF (item "c") × KAC proportion of OACs (item "b") × number of covered days for each inpatient admission.
    2. Accumulate d1 by county of beneficiary residence.

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

For future ratebook years, we will explore the use of KAC data provided by the MAC to the HSCRC to develop a KAC carve-out adjustment specifically for Maryland hospitals. Such data to develop a KAC carve-out adjustment specifically for Maryland hospitals is not currently available for CY 2025 ratebook development.

As described above, the approach to exclude costs for kidney acquisitions from MA benchmarks by county and from MA ESRD rates utilizes data from the Medicare cost reports and the inpatient PSF. These data sources do not include section 1881(d) expenditures for coverage of living donor expenses beyond what is reflected in the kidney acquisition cost center and paid on a pass-through basis in the Medicare FFS program. Per section 1853(k)(5) and (n)(2)(G) of the Act, the 1881(d) expenses are required to be included in the carve out of kidney acquisition costs from the benchmark amounts. Accordingly, we will tabulate from the FFS claim records the living donor expenses associated with kidney transplants and add those amounts to the KAC amounts derived from the cost reports. Per statute and as codified in §§ 422.100(c)(1) and 422.322(d), beginning in 2021, MA organizations are not responsible for coverage of organ

[21] Note that the sum of a1 through a7 is the same value as reported on Cost Report Worksheet E, Part A, line 55. Therefore, the proportion of organ acquisition costs that are applicable to kidneys could alternatively be computed by dividing a4 by Cost Report Worksheet E, Part A, line 55.

acquisition costs for kidney transplants incurred by MA enrollees, including coverage under section 1881(d) of living kidney donor expenses, which will be reimbursed by the Medicare FFS program.

When developing the CY 2025 rates, we will continue to apply the KAC adjustment subsequent to the application of the IME adjustment, consistent with the adjustment order used beginning with the CY 2022 ratebook.

Section C3. IME Phase Out

See Attachment I Section A regarding medical education expenses in USPCCs.

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. Payment to teaching facilities for IME expenses associated with MA plan enrollees will continue to be paid directly by CMS to hospitals. Section 1894(d)(3) of the Act provides that the IME payment phase-out does not apply to PACE capitation rates.

For purposes of making this adjustment for non-Maryland facilities, we will first calculate the FFS rates including the IME amount. The IME amounts are tabulated using the Indirect Medical Education Amount field included on inpatient records in the National Claims History (NCH) file. This initial amount will serve as the basis for calculating the IME reduction that we will carve out of the MA rates.

We are proposing to revise the data and methodology used to develop the IME carveout for hospitals participating in the Maryland TCOC Model. See section C1 for more information on the Maryland TCOC Model. The proposed adjustment will be based on IME included in the Provider Statistical & Reimbursement Report (PS&R) for Medicare Advantage (MA) admissions for each participating provider for each calendar year. The PS&R includes for each Maryland provider the fiscal year MA IME expenditures and MA days of admission, which are used to calculate the IME per diem for MA admissions. This MA experience is used as the basis for FFS IME amounts since IME payments for FFS admissions are not separately identified in the NCH for providers participating in the Maryland TCOC model.

The proposed adjustment is as follows:

1. Calculate average per diem IME amount for each TCOC facility and corresponding fiscal year ending in June as: IME amount from PS&R divided by days of admission from PS&R.

a. Actual PS&Rs and IME experience is available through FY 2022. The IME amounts are represented in the "From Intermediary Total IME & DME Payments" field on the Calculation of Medicare GME Discounts spreadsheets on HSCRC's Policy Clarifications and Regulations Updates web page.
b. Estimated IME per diem amounts for each facility for FY 2023 to be calculated as FY 2022 per diem amount multiplied by (1 + HSCRC's Proposed Inflation Update[22] for rate year 2023) or (1 + 0.046).

2. IME for each FFS claim in the NCH is tabulated as: per diem from step 1 applicable to facility and date of admission multiplied by number of covered days for each inpatient admission. This tabulation only applies to providers participating in the TCOC model.
3. Amounts from step 2 are accumulated by county of beneficiary residence based on the claims files.

The absolute effect of the IME phase-out on each county will be determined by the amount of IME included in the initial FFS rate. Under section 1853(k)(4)(B)(ii) of the Act, the maximum reduction for any specific county in 2025 is 9.6 percent of the FFS rate. Consistent with past practice, in order to help plans identify the impact, CMS will separately identify the amount of IME for each county rate in the 2025 MA ratebook.

Section D. MA ESRD Rates

Pursuant to section 1853(a)(1)(H) of the Act, CMS establishes "separate rates of payment" with respect to ESRD beneficiaries enrolled in MA plans. As we stated in the 2012 Rate Announcement (page 32), it is in keeping with our understanding of the legislative intent to more closely align MA payment rates with FFS costs that the MA ESRD rates are also based on FFS costs. We currently set MA ESRD rates on a state basis (that is, at the state level instead of the county level), using updated FFS costs each year, and intend to continue that policy and our existing methodology for setting MA ESRD rates.

We will use the 2018-2022 FFS expenditures and enrollment data for beneficiaries in dialysis status for each state to develop the CY 2025 MA ESRD rates. For each year, we compute the FFS dialysis per capita costs (for Part A and Part B items and services for beneficiaries in dialysis status) by state. The geographic indices for each year are calculated by dividing the state per capita cost by the national per capita cost. The five-year weighted average of the geographic indices is standardized by dividing by the five-year average risk scores (calculated using the risk

[22] Table 1, HSCRC's Final Recommendation for the Update Factors for Rate Year 2023, available from website: https://hscrc.maryland.gov/Documents/RY23FinalUFRecommendation_approved.pdf

adjustment model for CY 2025 payment). This standardized five-year weighted average is the AGA, which represents the ratio of historical FFS dialysis per capita costs by state to national FFS dialysis per capita costs. We calculated the 2022 FFS ESRD dialysis USPCC based on the 2022 data described above in Attachment I, Section A, and, using trend factors, develop the prospective 2025 FFS ESRD dialysis USPCC. The 2025 MA ESRD rates are determined by multiplying the 2025 FFS ESRD dialysis USPCC by the state AGA.

We will continue to incorporate refinements developed and used in prior years regarding the repricing of historical data in the AGA calculation for the MA ESRD rates. Similar to the non-ESRD rate methodology, we intend to reprice the ESRD historical inpatient, hospital outpatient, skilled nursing facility, and ESRD PPS claims from 2018-2022 to reflect the most current (i.e., FY 2024) wage indices, and re-tabulate physician claims with the most current (i.e., CY 2024) Geographic Practice Cost Indices. We will continue to adjust the UCPs represented in the 2018-2022 claims to reflect the requirements of the most recent final rule. The adjustments will also include shared savings and shared losses performance-based payments made under the CEC model, and population-based payments under the Next Gen ACO, Vermont Medicare ACO Initiative, and GPDC/REACH as described in section B3 of this document, as well as incentive payments under Advanced Alternative Payment Models. Pursuant to section 1853(k)(5), (n)(2)(A)(i) and (n)(2)(G), MA benchmarks for 2021 and subsequent years exclude organ acquisition costs for kidney transplants (described in detail in Section C above). As noted in the CY 2021 final rule (CMS-4190-F) (85 FR 33796, 33825) and in the CY 2021 Rate Announcement, the exclusion of KACs is also applied to the MA ESRD rates for 2021 and subsequent years. In addition, the 2025 MA ESRD rate is adjusted by removing the GME expenses and the gradual phase-out of IME expenses, consistent with adjustments made for the non-ESRD MA rates that are discussed in Sections B and C of this document.

We will publish a file with the CY 2025 Rate Announcement that includes the key components of the rate development, similar to the rate calculation data supporting the MA non-ESRD county rates.

As stated in Section C, CMS will continue to include organ acquisition costs for kidney transplants in the PACE rates, including PACE ESRD rates, and the IME payment phase-out does not apply to PACE capitation amounts. Therefore, for 2025, the ESRD rates for PACE organizations will continue to include KACs and IME amounts.

We are aware that stakeholders have raised concerns regarding ESRD payment adequacy and accuracy in recent years, in light of the increase in ESRD enrollment in MA plans as a result of the 21st Century Cures Act, which allows beneficiaries with ESRD to enroll in MA plans starting in 2021. In the CY 2023 and CY 2024 Advance Notices, we provided details of our analyses regarding potential changes to our development of the MA ESRD rates, including the impact of

rates at geographic levels smaller than the state by how geographic areas measured on the area deprivation index (ADI).The results of these analyses suggested some potentially concerning impacts on specific geographic areas if we were to change the geographic level at which we apply our methodology for developing the MA ESRD rates. CMS has analyzed the actual experience for ESRD enrollees for 2021 and 2022 as reported on Worksheet 1 of the CY 2023 and CY 2024 MA Bid Pricing Tools (BPTs). Our analysis indicates that 2021 and 2022 revenues for ESRD enrollees exceed the corresponding net medical expenses for most plans. Based on the analyses to date, we plan to continue our use of statewide MA ESRD rates for CY 2025.

As stated in section 1853(a)(1)(H) of the Act, and as implemented in § 422.304(c)(1)(iv), the seventh sentence of section 1881(b)(7) shall apply to payments under this section covering the provision of renal dialysis treatment. CMS will continue to withhold from the MA ESRD rates an amount equivalent to reducing each composite rate payment 50 cents per dialysis treatment per patient (currently calculated at $5.25 per month) for the ESRD Network Program.[23]

Section E. Location of Network Areas for Private Fee-for-Service (PFFS) Plans in Plan Year 2026

Section 1852(d)(4) of the Act requires MA organizations offering certain non-employer MA PFFS plans in network areas to enter into signed contracts with a sufficient number of providers to meet the access standards applicable to coordinated care plans. Specifically, non-employer MA PFFS plans that are offered in a network area (as defined in section 1852(d)(5)(B)) must meet the access standards described in section 1852(d)(4)(B) through written contracts with providers. These PFFS plans may not meet access standards by establishing payment rates that are at least the rates that apply under Medicare FFS and having providers deemed to be contracted as described in § 422.216(f).

Network area is defined in section 1852(d)(5)(B) of the Act, for a given plan year, as an area that the Secretary identifies (in the announcement of the proposed payment rates for the previous plan year under section 1853(b)(1)(B)) as having at least two network-based plans (as defined in section 1852(d)(5)(C)) with enrollment as of the first day of the year in which the Announcement is made. We intend to publish the list of network areas for plan year 2026 with the CY 2025 Rate Announcement. We will make this list available on the CMS website at: https://www.cms.gov/Medicare/Health-Plans/PrivateFeeforServicePlans/NetworkRequirements.

[23] For more information on the ESRD Network Program, visit https://www.cms.gov/training-education/open-door-forums/end-stage-renal-disease-clinical-laboratories-esrd/network

Section F. MA Employer Group Waiver Plans (EGWP)

We intend to continue to waive the Bid Pricing Tool bidding requirements for all MA employer/union-only group waiver plans (EGWPs) for 2025.[24] As a condition of this waiver of the bidding requirements and the waivers otherwise provided to MA EGWPs, CMS will establish MA EGWP payment amounts using the same methodology for 2025 as was used for 2024. As has been the case since 2017, for 2025, Part C entities offering EGWPs will not be required to submit Part C bid pricing information in the Part C Bid Pricing Tool. CMS has authority under section 1857(i) of the Act to waive or modify requirements that hinder the design of, the offering of, or the enrollment in employment-based Medicare plans offered by employers and unions to their members. Waiving the requirement to submit Part C bid pricing information facilitates the offering of Part C plans for employers and unions seeking to establish high quality coverage for their Medicare-eligible retirees by avoiding the cost and administrative burden of submitting the complex bids required from non-EGWPs. We refer the reader to the detailed discussion of our rationale and responses to commenters' questions in the CY 2017 Rate Announcement, Attachment III, Section F (pages 27–44) for additional information, and to the responses to questions received by the Office of the Actuary that are available at: https://www.cms.gov/Medicare/Health-Plans/MedicareAdvtgSpecRateStats/ActuarialBidQuestions.

F1. Bid-to-Benchmark Ratio

In connection with the continuation of this waiver, for 2025, CMS will continue to use the payment methodology for MA EGWPs that was finalized in the CY 2024 Rate Announcement. For 2025, we will use bid-to-benchmark ratios based on 2024 bids and weighted by February 2024 enrollment, which is generally consistent with how we have developed these EGWP payments since 2019. With the exception of the 2022 bid-to-benchmark ratio which was weighted by January 2021 enrollment, bid-to-benchmark ratios have been weighted by the February enrollment of each year since 2019. For 2025, the bid-to-benchmark ratio will be weighted by February 2024 enrollment.

As a result of feedback from the industry on the CY 2022 bid cycle, CY 2023 was the first year that CMS published preliminary bid-to-benchmark ratios for EGWPs in the Advance Notice. MA organizations indicated that having this information early provides valuable information in their negotiations with employer/union groups to create more accurate benefit and premium quotes for their MA EGWP enrollees. However, these ratios are based on 2024 bids and weighted by January 2024 enrollment instead of the February 2024 enrollment that we intend to

[24] As stated in the Medicare Managed Care Manual, Ch. 9, § 10.2., in addition to EGWPs, employer/union group health plan sponsors may choose to enroll their Medicare beneficiaries in individual MA plans. These MA plans do not qualify for the employer/union group health plan waiver of bidding requirements described in this section.

use for the final ratios; these preliminary ratios are not final and could differ from the ratios that are ultimately published in the Rate Announcement, so we recommend that caution be used in reviewing them. The preliminary bid-to-benchmark ratios are as follows:

Table II-6. Preliminary Bid-to-Benchmark Ratios

Applicable Percentage	Bid to Benchmark Ratio
0.95	78.5%
1	76.8%
1.075	76.2%
1.15	76.6%

The payment methodology for MA EGWPs relies on bid-to-benchmark ratios, as described below, that reflect average bid amounts, weighted by plan enrollment. The calculations for the bid-to-benchmark (B2B) ratios for CY 2025 would therefore be as follows:

> First: [(Weighted Average of the Intra-Service Area Rate Adjustment (ISAR) Adjusted County Bid Amounts for 2024 Individual Market Plan Bids by February 2024 Actual Enrollment)/(Weighted Average of the County Standardized Benchmarks for 2024 Individual Market Plans by February 2024 Actual Enrollment)] = 2024 Individual Market B2B Ratios by Quartile.[25]
>
> Second: The 2024 individual market B2B ratios will be calculated separately for HMO plan types and PPO plan types by quartile.[26] The PPO B2Bs by quartile will be weighted by the total proportion of EGWP PPO plan type enrollment, and the HMO B2Bs by quartile will be weighted by the total proportion of EGWP HMO plan type enrollment to result in the final B2B ratios for 2025 by quartile.

As has been in effect since 2017, for 2025:

- The B2B ratios will be applied to each of the published 5%, 3.5%, and 0% quality bonus percentage county ratebook rates for the payment year to establish Part C base payment amounts for EGWPs based on their Star Rating, for each county.

[25] As in prior years, territories will not be included in the weighted average B2B ratios, but they will be assigned the weighted average of the quartile within which their counties fall. To determine the CY 2025 applicable percentages, CMS ranks counties from highest to lowest based on their 2024 average per capita FFS costs and places the rates into four quartiles. When calculating the 2024 B2B ratios, CMS will group counties by the 2024 unblended quartiles and will then apply these B2B ratios to the 2025 unblended quartiles.

[26] Consistent with how we have developed EGWP payments since 2019, HMO and HMOPOS plans have been combined into an "HMO plan type" and LPPO and RPPO plans have been combined into a "PPO plan type." "HMO" Health Maintenance Organization, "HMOPOS" Health Maintenance Organization Point of Service, "PPO" Preferred Provider Organization, "LPPO" Local Preferred Provider Organization, "RPPO" Regional Preferred Provider Organization. "PFFS" Private Fee-for-Service individual market plans are excluded from these calculations.

- In order to calculate a county rebate payment, each county-level EGWP Part C base payment amount will be compared to the corresponding published 5%, 3.5%, and 0% quality bonus percentage county benchmarks for the payment year (2025), which include adjustments for qualifying counties, to determine the amount of savings. The savings amount will be multiplied by the corresponding rebate percentage to determine the Part C EGWP county-level rebate amount.
- The EGWP Part C base payment amount will be added to the Part C EGWP rebate amount to establish the county-level local EGWP total payment amount.
- The total payment amount will be risk adjusted using beneficiary-specific risk scores. Therefore, the formula applied for local EGWP payment on a per-beneficiary basis would be: (Base County Payment Rate + County Rebate) × Beneficiary-Level Risk Score.

For RPPO EGWPs, the weighted-average B2B ratios will continue to be calculated as described above. To establish the Part C base RPPO EGWP payment amount, we will then also continue to apply the same methodology as described above.

In order to calculate the RPPO EGWP rebate amounts, these percentages will continue to be applied for each county within a region to the published payment year regional benchmarks to establish the savings amount and rebate amounts by Star Rating and quartile.

The RPPO EGWP Payment Formula continues to be (Base County Payment Rate + Regional Rebate) × Beneficiary-Level Risk Score, where each is calculated as follows:

- Base County Payment Rate = Bid to Benchmark Ratio × 2025 MA Monthly Capitation Rate
- Regional Rebate = (1 − Bid to Benchmark Ratio) × 2025 Regional Rate × Rebate Percentage
- The 2025 Regional rate is based on a blend of the statutory and bid component. As with non-EGWPs, if there is no bid component of the 2025 Regional rate (i.e., no individual bids in a region), then the EGWP rate will be based solely on the statutory component.

As has been the case since 2017, for 2025, there will be no Part C Regional PPO EGWP bids to include in the calculation of the MA regional benchmarks. The statutory components of the regional standardized A/B benchmarks will continue to be published each year as part of the Announcement of Medicare Advantage Payment Rates. CMS will also continue to publish the final MA regional standardized A/B benchmarks in late summer, which will reflect the average bid component of the regional benchmark based on non-EGWP bid submissions.

F2. MA Rebates and Part B Premium Buy-Down

As part of the waiver of the requirement for EGWPs to submit bid pricing information, CMS will continue to waive the requirement that MA EGWPs must specify how they are allocating MA rebate dollars (other than the buy-down of the Part B premium) for 2025. However, the limits set forth in § 422.266 regarding how the MA rebate may be used have not been waived and therefore continue to apply for EGWPs. CMS does not distinguish the amount to be allocated for rebates in calculating payments to MA EGWPs; however, if the MA EGWP elects to treat part of the payment as an MA rebate, how the rebate portion of the payment may be used is subject to the requirements at § 422.266. Thus, an EGWP could designate no part of its payment from CMS as MA rebates, or it could designate a portion of its payment as MA rebates and apply these designated rebate amounts to pay for mandatory supplemental benefits in accordance with § 422.266(b)(1) or to buy down Part B or Part D premiums in accordance with § 422.266(b)(2) and (b)(3). However, the MA EGWP could not use MA rebates to pay for optional supplemental benefits, as this is prohibited by § 422.266(b)(1).

For 2025, we will also continue the existing policy permitting MA EGWPs to buy down Part B premiums for their enrollees using a portion of the Part C payment that the MA EGWP has designated as MA rebates.

As has been the case since 2020, MA EGWPs will be subject to the same maximum Part B buy-down amount as non-EGWP plans. That is, EGWPs may only buy down the Part B premium up to the maximum amount displayed in the CY 2025 MA Bid Pricing Tool Worksheet 6. Additionally, as with non-EGWP plans, the Part B premium buy-down amount cannot vary among beneficiaries enrolled in an EGWP. The Part B buy-down amount applies to every beneficiary under the plan ID. Therefore, if an EGWP would like to reduce the Part B premium for one employer group under the plan ID by $5 and reduce the Part B premium for another employer group by $10, then the MA organization must establish two separate EGWP plan IDs (i.e., two separate Plan Benefit Packages (PBPs)), each with the specific amount to buy-down the Part B premium. In this example, the PBP for plan 801 would contain a $5 buy-down amount, and the PBP for plan 802 would contain a $10 buy-down amount.

We will continue to collect a Part B premium buy-down amount in the EGWP's PBP submission to CMS. Any MA EGWP that chooses to use a portion of its payment to buy down the Part B premium must apply such Part B premium buy-down amount consistently to every beneficiary enrolled in the EGWP in accordance with uniformity of benefit rules, which are not waived for EGWPs in connection with buy-downs of Part B premiums. Those MA EGWPs that choose to designate a portion of their payment as MA rebates to buy down the Part B premium for their enrollees will have that amount reduced from their capitated payment. For example, if an MA EGWP determines that under its benefit offering there will be a $5 reduction to each enrollee's

Part B premium, $5 per member per month will be entered into the requisite field in the PBP, and then $5 will be subtracted from the monthly capitated amount. For local MA EGWPs, this is reflected in the payment formula described above as follows:

Total Payment = (Base County Payment Rate + County Rebate) × Beneficiary Level Risk Score - *Part B Buy Down Amount*.

MA EGWPs will continue to be prohibited from separately refunding Part B premiums for their enrollees outside of this process.

F3. Additional Adjustments

The following rules will continue to apply as they have since 2017 under the EGWP payment methodology:

- MA EGWPs will not receive capitation payments for hospice care. For more information about how an MA enrollee electing hospice affects payments to MA plans, please see § 422.320.
- MA EGWPs will continue to be paid using the ESRD ratebook for their ESRD beneficiaries in Transplant and Dialysis status and the individual market MA ratebook for those beneficiaries in Functioning Graft status, in keeping with the current payment policy for non-EGWP MA organizations.
- Consistent with how CMS pays capitation for Part B-only enrollees in the non-EGWP context, Part B-only MA EGWPs will continue to receive only the Part B portion of the EGWP payment amount, which is determined by multiplying it by the Part B percentage of the MA rate.
- MA EGWP MSA plans will continue not to submit Bid Pricing Tools for 2025, but the 2025 local EGWP payment rates will continue to not be applied to EGWP MSA plans. The monthly prospective payments for EGWP MSAs will be based on the following formula: 2025 MA Monthly Capitation County Rate × beneficiary risk score – 1/12 of the Annual MSA Deposit Amount. The 2025 Annual MSA Deposit Amount must be submitted in the appropriate PBP field. Consistent with individual market MSA plans, MA EGWP MSA plans are not able to use a portion of the Part C payment to buy down the Part B premium.

Notwithstanding the payment policies described above, entities offering MA EGWPs must continue to meet all of the CMS requirements that are not otherwise specifically waived or modified, including, but not limited to, submitting information related to plan service areas, PBPs, and formularies in accordance with the rules for 2025. MA organizations must continue to

make a good faith effort in projecting CY 2025 member months for each plan and place the amount in the appropriate section of the CY 2025 PBP submissions to CMS.

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

In the 2024 Rate Announcement, CMS finalized an updated risk adjustment model, referred to as the 2024 CMS-HCC model, with the intention to phase it in over three years, with full implementation of the model in payment year 2026.[27] The 2024 CMS-HCC model included important technical updates to improve the predictive accuracy of the model, including restructured condition categories using the International Classification of Diseases (ICD)-10 classification system (instead of the ICD-9 classification system), updated underlying FFS data years (from 2014 diagnoses and 2015 expenditures to 2018 diagnoses and 2019 expenditures), an updated "denominator year" in determining the average per capita predicted expenditures to create relative factors in the model, as well as applying our longstanding principles to make revisions focused on conditions that are subject to more coding variation. These updates help to ensure that higher payments are available to plans that serve beneficiaries who are expected to be more costly.

For CY 2024 payment, risk scores are calculated as a blend of 67 percent of the risk scores calculated with the 2020 CMS-HCC model and 33 percent of the risk scores calculated with the updated 2024 CMS-HCC model. In the CY 2024 Rate Announcement, we stated our intention to calculate CY 2025 risk scores as a blend of 33 percent of the risk scores calculated with the 2020 model and 67 percent of the risk scores calculated with the 2024 model. Please refer to the 2024 Advance Notice and Rate Announcement for additional details.[28]

Continued Phase-in of Updated CMS-HCC Model in CY 2025

For CY 2025, CMS proposes to continue to phase in the implementation of the 2024 CMS-HCC risk adjustment model, as described in the CY 2024 Rate Announcement. Specifically, CMS proposes to calculate risk scores for CY 2025 using the sum of:

- 33 percent of the risk score calculated with the 2020 CMS-HCC model and
- 67 percent of the risk score calculated with the 2024 CMS-HCC model.

Upon careful analysis of the impacts of the model, including for dually eligible beneficiaries and dual SNPs, CMS has concluded that continuing to implement the 2024 CMS-HCC model is

[27] Announcement of Calendar Year (CY) 2024 Medicare Advantage (MA) Capitation Rates and Part C and Part D Payment Policies.

[28] 2024 Advance Notice: https://www.cms.gov/files/document/2024-advance-notice-pdf.pdf
2024 Rate Announcement: https://www.cms.gov/files/document/2024-announcement-pdf.pdf

necessary and appropriate. This conclusion is informed in part by plan bidding for 2024, which signaled strong growth in the dual SNP market for 2024 with the number of dual SNPs increasing by approximately 8 percent and projected enrollment in dual SNPs increasing by approximately 12 percent. The 2024 CMS-HCC model improves payment accuracy by using more recent data to reflect more recent cost and utilization patterns and by including condition categories developed using ICD-10 codes that reliably predict Medicare costs. Continued phase in of the updated model ensures MA payments more accurately reflect more recent relative cost (2019 compared to 2015) and include clinically meaningful conditions that predict cost developed from experience with ICD-10, thereby ensuring plans are adequately paid for the sickest and most complex enrollees. For reference, we have included in Attachment VII the 2024 CMS-HCC model predictive ratios that were published in the 2024 Rate Announcement, which show improved predictive accuracy across segments including for enrollees entitled to Medicare because of age or disability who are dually eligible for Medicaid and Medicare (duals). Updating the 2024 CMS-HCC risk adjustment model with HCCs developed using ICD-10 codes aligned the model with the rest of the health care system, which has been using ICD-10 since 2015.

MA Risk Score Trend

We also provide information here regarding the MA risk score trend that we include in the 2025 Fact Sheet and FAQs that accompany the release of this document. CMS annually estimates the MA risk score trend, which is the estimated industry average annual change in MA risk scores in the payment year. The MA risk score trend is estimated as the average annual change in MA risk scores (i.e., the slope) over a three-year period calculated using the model(s) proposed for the payment year. CMS provides the MA risk score trend as an essential element for understanding the full revenue picture for MA organizations in the payment year. In a year where we are blending the risk scores from two risk adjustment models, the MA risk score trend for each model is first calculated separately and then blended by the respective percentage. For CY 2025, the MA risk score trend was calculated using MA risk scores from 2018 through 2020 (the most recent three years of continuous data not affected by the COVID-19 pandemic). The risk score trend is 3.30 percent under the 2024 CMS-HCC model and 5.00 percent under the 2020 CMS-HCC model. CMS blended the MA risk score trends using the same blend proposed to be used to determine CY 2025 risk scores (i.e., 67 percent of the MA risk score trend under the 2024 CMS-HCC model and 33 percent under the 2020 CMS-HCC model). This blended MA risk score trend for CY 2025 is 3.86 percent. This MA risk score trend accounts for the average change in population and coding practices across all MA plans; these trends can vary among individual MA plans in terms of their plan-specific payment impacts.

CMS-HCC Model for PACE Organizations

For CY 2025 payments to PACE organizations, we will continue to use the 2017 CMS-HCC model to calculate risk scores, which we began using for CY 2020 payments to PACE organizations as described in the CY 2020 Advance Notice Part II[29] and the CY 2021 Advance Notice Part I.[30] The 2017 CMS-HCC model was calibrated using FFS diagnoses that were selected using specialty-based filtering logic which is the same filtering method used to calculate risk scores for PACE organizations. Whereas more recent versions of the CMS-HCC model used to calculate non-PACE organization risk scores are calibrated using FFS diagnoses that were selected using the same filtering method that is used for encounter data. These models are intended to calculate risk scores using diagnoses submitted on encounter data records and on FFS claims that were filtered in the same manner as encounter data records. Because we are not currently calculating PACE beneficiary risk scores using diagnoses solely from encounter data and FFS claims, it would not be appropriate to implement one of the more recent versions of the CMS-HCC risk adjustment model for PACE for CY 2025.

Refer to Section L for information on encounter data as a source of diagnoses for CY 2025 risk score calculation. Section L1 discusses the activities CMS has taken towards transitioning PACE organizations to fully submitting diagnoses into the encounter data system in anticipation of future implementation of a more recent version of the CMS-HCC risk adjustment model.

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

CMS uses separate models to calculate the risk scores applied in payment for the Part A and Part B benefits provided to beneficiaries in ESRD status when enrolled in MA plans or PACE organizations.

For CY 2025, for MA plans, CMS will continue to use the 2023 ESRD risk adjustment models, which are described in the CY 2023 Advance Notice,[31] to calculate risk scores for beneficiaries in dialysis, transplant, and post-graft status.

For CY 2025, for PACE organizations, CMS will continue to use the 2019 ESRD risk adjustment models, which are described in the CY 2019 Advance Notice,[32] to calculate ESRD risk scores for PACE participants.

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[29] CY 2020 Advance Notice Part II

[30] CY 2021 Advance Notice Part I

[31] CY 2023 Advance Notice (Section H): https://www.cms.gov/files/document/2023-advance-notice.pdf

[32] CY 2019 Advance Notice

Refer to Section L for information on encounter data as a source of diagnoses for CY 2025 ESRD risk score calculation.

Section I. Frailty Adjustment for PACE Organizations and FIDE SNPs

While the CMS-HCC model predicts future Medicare expenditures of individuals based on their demographic and clinical characteristics, the model may not explain all of the variation in expenditures for frail community populations. The purpose of the frailty adjustment is to predict the Medicare expenditures of community populations with functional impairments that are unexplained by the diagnoses in the CMS-HCC model.

Section 1894(d)(2) of the Act requires CMS to take into account the frailty of the PACE population when establishing the capitated payment amounts for PACE organizations. In addition, section 1853(a)(1)(B)(iv) of the Act allows CMS to make an additional payment adjustment that takes into account the frailty of beneficiaries enrolled in Fully Integrated Dual Eligible Special Needs Plans (FIDE SNPs), if the average level of frailty in the FIDE SNP is similar to that in the PACE program. For PACE organizations and eligible FIDE SNPs, we make this adjustment by adding a frailty score to a beneficiary's risk score.

CMS calibrates the frailty factors by regressing the residual, or unexplained, costs from the CMS-HCC risk adjustment model onto counts of activities of daily living (ADLs). Residual costs are unique to each version of the CMS-HCC model, and consequently, so are the frailty factors. For this reason, CMS must update the frailty factors whenever the CMS-HCC model changes. The frailty factors are calibrated to align with the CMS-HCC risk adjustment model using data regarding limitations on ADLs from the Medicare FFS Consumer Assessment of Health Providers & Systems (CAHPS) survey. There are six ADLs: 1) bathing and showering, 2) dressing, 3) eating, 4) getting in or out of bed or chairs, 5) walking, and 6) using the toilet.

By using the FFS CAHPS results to calibrate the frailty factors, CMS uses methodologically-similar surveys to estimate the frailty factors, and for calculating annual frailty scores (which uses ADLs from the Health Outcomes Survey (HOS) and the Health Outcomes Survey – Modified (HOS-M)). To calculate frailty scores for payment, CMS uses the number of functional limitations represented by the ADL scale to determine the relative frailty of those in the community who are 55 years of age and older.

FIDE-SNPs

For CY 2025, CMS is proposing to continue using the frailty factors finalized in CY 2024. In the CY 2024 Rate Announcement, CMS updated the frailty factors to align with the 2024 CMS-HCC model. We continue to consider the recalibrated factors finalized in the CY 2024 Rate Announcement to be an appropriate measure of predicted residual costs from the model for the

survey population. As noted in the 2024 Rate Announcement, when CMS recalibrated the frailty factors for the 2024 CMS-HCC model we noticed differences in the frailty factor patterns relative to prior years. In the 2024 Rate Announcement, we noted our intention to research the pattern changes. CMS continues to evaluate the underlying patterns driving the changes in the frailty factors in recent years. Once complete, we will take our findings under consideration when making future updates to the frailty factors.

For CY 2025, CMS is proposing to blend the frailty score calculated for FIDE SNPs consistent with the phase-in of the 2024 CMS-HCC Model. As such, the FIDE SNP frailty score would be calculated as the sum 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.

The 2020 and 2024 CMS-HCC model frailty factors are in Table II-7 and Table II-8, respectively.

Table II-7. Frailty Factors Associated with the 2020 CMS-HCC Model – FIDE SNPs
(Previously published in the CY 2023 Advance Notice and finalized in the CY 2023 Rate Announcement[33])

ADL	Non-Medicaid	Partial Medicaid	Full Medicaid
0	-0.066	-0.140	-0.082
1-2	0.102	0.000	0.217
3-4	0.227	0.142	0.282
5-6	0.227	0.142	0.282

Table II-8. Frailty Factors Associated with the 2024 CMS-HCC Model – FIDE SNPs
(Previously published and finalized in the CY 2024 Rate Announcement[34])

ADL	Non-Medicaid	Partial Medicaid	Full Medicaid
0	-0.066	-0.070	0.158
1-2	0.103	0.203	0.230
3-4	0.201	0.203	0.230
5-6	0.201	0.217	0.248

MA organizations that are planning to sponsor a FIDE SNP and wish to be considered for frailty payments in 2025 must contract with a CMS-approved survey vendor to field the 2024 HOS or

[33] CY 2023 Advance Notice, Section J and the CY 2023 Rate Announcement, Section K

[34] CY 2024 Rate Announcement, Section L

HOS-M at the PBP level so that the necessary information to calculate a frailty adjustment for the FIDE SNP's risk scores is available. For FIDE SNPs, CMS uses plan-level ADL information obtained from the HOS or HOS-M in one year to calculate frailty scores for the following year by applying the frailty factors that correspond to the ADL information gathered from the HOS or HOS-M data.

Changes for FIDE-SNPs in CY 2025:

In the CY 2023 final rule (CMS-4192-F, 87 FR 27741) titled "Medicare Program; Contract Year 2023 Policy and Technical Changes to the Medicare Advantage and Medicare Prescription Drug Benefit Programs; Policy and Regulatory Revisions in Response to the COVID–19 Public Health Emergency; Additional Policy and Regulatory Revisions in Response to the COVID–19 Public Health Emergency," we finalized at § 422.2 that FIDE SNPs must have "exclusively aligned enrollment." As a result, beginning for plan year 2025, enrollment in FIDE SNPs will be limited to full-benefit dually eligible individuals who are also enrolled in an affiliated Medicaid Managed Care Organization (MCO) for coverage of Medicaid benefits. Therefore, the frailty factors for non-dual and partial-benefit dually eligible individuals included in this Advance Notice generally would not be applicable to the beneficiaries who are enrolled in FIDE SNPs beginning plan year 2025.

The 2024 CMS-HCC model frailty factors are calculated using segments that align with the CMS-HCC model (i.e., non-dual, partial benefit dual, and full benefit dual). To calculate the frailty factors, the monthly costs associated with a beneficiary in the frailty sample are assigned to the applicable model segment. The actual and predicted expenditures are then annualized to account for partial months. The frailty factors for each segment are then estimated by regressing the residual cost for each segment onto the ADLs. The full Medicaid frailty factors represent the residual costs by ADL that are not predicted by the model specifically for full-benefit dually eligible beneficiaries.

While we anticipate that all 2025 enrollees in FIDE SNPs will be reported as full-benefit dually eligible individuals in compliance with the new limits, CMS will continue to rely on the data as submitted on the MMA State files, the Point of Sale data, and the Commonwealth of Puerto Rico monthly Medicaid file to determine the dual status of a beneficiary.

Frailty scores are calculated using responses to the HOS or HOS-M survey conducted in the year prior to the payment year (e.g., 2025 frailty scores will be calculated from 2024 survey responses). Because FIDE SNP enrollment in CY 2024 will include beneficiaries who do not have full Medicaid benefits, the survey responses used for CY 2025 for FIDE SNPs may include partial-benefit dually eligible individuals. For CY 2025 only, regardless of their 2024 dual status,

only the full Medicaid frailty factors will be used to calculate FIDE SNP frailty scores for FIDE SNP enrollees. Specifically, for CY 2025 only, we will calculate FIDE SNP frailty scores using all applicable respondents, but we will use the full Medicaid frailty factors in the calculation of the frailty scores for FIDE SNP enrollees regardless of a respondent's 2024 Medicaid status, meaning that we will use full Medicaid factors even for non-dual and partial-benefit dually eligible individuals that match their count of ADLs (e.g., 0, 1-2, 3-4, 5-6). Payment using the full Medicaid frailty factors in CY 2025 will therefore be consistent with the requirement that enrollment in FIDE SNPs be limited to full-benefit dually eligible individuals starting in CY 2025.

CMS will estimate the PACE minimum frailty score used as the threshold to establish whether a FIDE SNP qualifies to receive a frailty adjustment in CY 2025 in the same manner proposed to calculate FIDE SNP frailty scores (i.e., using the full Medicaid frailty factors for all PACE participants). CMS anticipates applying the full Medicaid factors this way for FIDE SNPs and when calculating the PACE minimum frailty score only for payment year 2025 because during the survey year for payment year 2026 (i.e., CY 2025) the dual status of FIDE SNP beneficiaries surveyed is expected to align with the FIDE SNP enrollment requirements.

PACE Organizations

For CY 2025, CMS will continue calculating risk scores for beneficiaries enrolled in PACE organizations using the 2017 CMS-HCC model and will use the frailty factors associated with the 2017 CMS-HCC model (Table II-9) to calculate frailty scores for PACE organizations in CY 2025.

Table II-9. Frailty Factors Associated with the 2017 CMS-HCC Model – PACE Organizations
(Previously published and finalized in the 2017 Rate Announcement[35])

ADL	Non-Medicaid	Medicaid
0	-0.083	-0.093
1-2	0.124	0.105
3-4	0.248	0.243
5-6	0.248	0.420

[35] CY 2017 Rate Announcement, Section J.

Section J. Medicare Advantage Coding Pattern Difference Adjustment

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

Section K. Normalization Factors

The CMS-HCC risk adjustment models are calibrated with diagnostic and cost information for beneficiaries enrolled in Medicare FFS. The risk adjustment models are prospective in that they use health status in a base year (i.e., data collection year) to estimate incremental costs for a variety of beneficiary characteristics (e.g., age and gender) and health conditions in the following year (i.e., the payment year). To create relative factors, each model variable's incremental cost estimate, referred to as a dollar coefficient, is divided by the predicted average per capita expenditure for beneficiaries in the Medicare FFS program in a given year (i.e., the denominator year). Risk scores are the sum of relative factors assigned to each beneficiary based on their demographic characteristics and health status from the prior year. The average risk score is 1.0 among FFS beneficiaries in the denominator year.

The average FFS risk score changes each year due to an underlying trend that reflects changes in the health status and demographic characteristics of the population, and coding practices. Therefore, when a risk adjustment model predicts expenditures in years other than the denominator year, the average FFS risk score may no longer be 1.0, as it was in the denominator year. Accordingly, an adjustment must be applied to account for the FFS risk score trend between the denominator year and payment year. For example, the updated CMS-HCC model (non-PACE, non-ESRD) that is being phased in (also called the 2024 CMS-HCC model) has a denominator year of 2020 and the 2020 CMS-HCC model (non-PACE, non-ESRD), which is being phased out, has a denominator year of 2015. CMS applies a normalization factor to risk scores in the payment year to account for this trend in the average FFS risk score between the denominator year and the payment year. The normalization factor is a projection of the average FFS risk score based on the trend and we apply it by dividing each individual risk score in the payment year by the normalization factor. Doing so effectively keeps the average FFS risk score at 1.0 in the payment year.[36] For the normalization factor to work as intended, CMS must predict an average FFS risk score that is a reasonably accurate projection of the future payment year's average FFS risk score, given the historical FFS information available at the time the normalization factor is calculated. See also 2025 Fact Sheet and FAQs that accompany the release of this document for information on this topic.

[36] See section 1853(a)(1)(C)(i) of the Act, which authorizes use of additional adjustment factors to improve the determination of actuarial equivalence, and section 1853(a)(1)(C)(ii)(I) of the Act, which requires that the risk adjustment used in MA payment reflects changes in treatment and coding practices in the fee-for-service sector.

Since 2007, CMS has largely used the same linear slope methodology for calculating normalization factors, which is to calculate a slope using five years of risk scores calculated using the payment year model, then projecting the slope by the number of years between the denominator year and the payment year. For normalization factors for payment years prior to CY 2023, we updated the data points used to calculate the slope for each risk adjustment model by dropping the earliest year's FFS risk score and adding the most recent year's FFS risk score so that the slope used for projection was based on the most recent FFS risk scores available. To calculate the normalization factor using this method, we first calculate the slope from the five-year trend of historical risk scores after which we apply the equation (1+X)^n – where X is the slope, and the exponent, n, is the number of years between the denominator year and the payment year.

The pandemic caused significant uncertainty for the FFS risk score trend. Prior to the pandemic, CMS observed that FFS risk scores continuously increased year over year by more than one percent. FFS risk scores decreased significantly from 2020 to 2021. The FFS trends from 2021 to 2023 are higher than FFS risk score trends before the pandemic. For example, from 2021 to 2022, the average FFS risk score (calculated using the 2024 CMS-HCC model) decreased by 3.2 percent, then, from 2021 to 2022, the average FFS risk score increased 2.5 percent and from 2022 to 2023, that average risk score increased 1.7 percent (see subsections K1 through K3 for average FFS risk scores from 2016 to 2023 for each CMS-HCC model).

For payment years CY 2023 and CY 2024, in the absence of additional information on how the average FFS risk score would change as the COVID-19 pandemic subsided and, therefore, what the average FFS risk score would likely be for those payment years, we continued our long-standing normalization methodology with modifications to account for the effects of the pandemic on the trend.

For CY 2023, CMS scrutinized the inclusion of the 2021 average FFS risk score in the calculation, which is based on 2020 dates of service that were heavily impacted by the pandemic. Instead of updating the data points used to calculate the slope, by adding a year and dropping a year, as we had typically done in the past prior to the pandemic, CMS calculated the normalization factors for the risk adjustment models by excluding the atypically low average 2021 FFS risk score (based on 2020 dates of service) and maintaining the five years in the slope that were used for CY 2022 (2016-2020).[37]

For CY 2024, CMS again carefully considered the average 2021 FFS risk score as well as the average 2022 FFS risk score (based on 2021 dates of service). Using the available average FFS risk score data (through 2022), CMS concluded that to calculate a reasonably accurate

[37] See the CY 2023 Advance Notice and Rate Announcement.

normalization factor it should move up data years from 2016-2020 to 2018-2022, but continue to exclude 2021 average FFS scores for models with a 2019 or 2020 denominator, and continue using the 2016-2020 data years for models with a 2015 denominator.[38] As explained in the CY 2023 and CY 2024 Advance Notices and Rate Announcements, CMS's proposal and final policy for setting normalization factors was based on balancing the incorporation of the newest data possible and the impact of the pandemic on the normalization factor projection and the progressive increase in FFS risk scores evident in the actual data available on the FFS historical trend.

For CY 2025, CMS is again examining the inclusion of data years impacted by the pandemic and, given our findings, as discussed below, we also assessed a methodology that would most accurately account for the FFS average risk score trend since the beginning of the pandemic. We considered impacts on all normalization factor calculations, including the 2024 CMS-HCC model (denominator year 2020), the 2020 CMS-HCC model (denominator year 2015), the CMS-HCC models with a 2019 denominator (i.e., the 2023 ESRD dialysis and 2023 ESRD functioning graft models), and other models with a 2015 denominator year (2017 CMS-HCC model used for PACE organizations, and the 2019 ESRD dialysis and 2019 ESRD functioning graft models used for PACE organizations).

First, we considered whether it remained supportable to use the same methodology as we did for CY 2024 for determining the normalization factors, meaning using a linear slope approach that moves up the data years. Our analysis showed that when the CY 2025 normalization factor for the 2024 CMS-HCC model is calculated with a slope using the most recent average FFS risk scores (2019 through 2023, excluding 2021), the resulting normalization factor is the same as the CY 2024 normalization factor, predicting that average FFS risk scores would not grow between CY 2024 and CY 2025. Given historical FFS risk score growth, post-pandemic, including recent 2023 FFS data, we do not believe that a prediction that average FFS risk scores from 2023 to 2025 will remain flat is supportable. Additionally, when considering the 2020 CMS-HCC model, we observed that when using the 2019 through 2023 average FFS risk scores in the trend and excluding only the 2021 average FFS risk score, the resulting normalization factor is lower than the actual 2023 FFS risk score, which we also do not believe is reasonable. As such, CMS explored other FFS normalization calculation methodologies for CY 2025.

Second, CMS considered keeping the existing linear slope. methodology for all FFS normalization calculations and including the most recent average FFS risk score available, which is 2023, but excluding both the 2021 and 2022 average FFS risk scores (i.e., 2019 through 2023, excluding 2021 and 2022). This approach allows CMS to include the most recent average FFS risk scores (2023); however, it requires the exclusion of two data years. Using this approach

[38] See the CY 2024 Advance Notice and Rate Announcement.

results in a projection of the average 2025 FFS risk score for the 2024 CMS-HCC model that increases the normalization factor year over year by 0.7 percent. Furthermore, when considering the 2020 CMS-HCC model (2015 denominator year) using this method, we observed that when using the 2019 through 2023 risk scores in the trend and excluding only the 2021 risk score and the 2022 risk score, the resulting normalization factors are lower than the actual 2023 FFS risk score. Such a factor would indicate a projection that the average 2025 FFS risk score will be lower than the actual 2023 average FFS risk score for the 2020 CMS-HCC model. We also believe this is not a reasonable projection based on past growth in average FFS risk scores post-COVID-19, and CMS's expectation is that the average FFS risk score will not go down between 2023 and 2025, but rather that it will continue to grow year over year. Additionally, while weighing using the existing linear slope approach but deleting 2021 and 2022 risk scores, CMS considered comments the agency has received that raise concerns about excluding data years in developing a trend to set the normalization factor. Commenters have also recommended careful treatment of data years that include average FFS risk scores impacted by the pandemic. CMS agrees that using the most recent available FFS risk score data can be important to increasing the accuracy of our projections and it is important to treat years impacted by COVID-19 carefully. As noted above, we must also balance these considerations with ensuring that we apply a methodology that produces a normalization factor that reasonably accurately predicts changes in risk scores such that a 1.0 average FFS risk score is maintained in the payment year.

Third, we considered using the existing methodology using data from 2020 and later, which would isolate the potential impacts of the pandemic on risk scores, and which would reflect that post-COVID-19 experience is different than pre-COVID-19 FFS experience data. Using this approach, we used average FFS risk scores from 2022 and 2023. This results in projecting roughly 8 percent average FFS risk score growth from 2023 to 2025 for the updated 2024 CMS-HCC model and 16 percent average FFS risk score growth from 2023 to 2025 for the 2020 CMS-HCC model. We do not find this result reasonable because historically FFS risk scores have grown between 1 and 3 percent per year for the 2024 CMS-HCC model and the 2020 CMS-HCC model (excluding the anomalous decrease in risk scores in 2021).

Because excluding data years under the linear slope methodology does not produce reasonable projections and is no longer supportable when considering the actual 2023 average FFS risk score, CMS developed and is proposing a more sophisticated multiple linear regression methodology for calculating normalization factors for CMS-HCC models for CY 2025. This new methodology would allow CMS to incorporate the most recent average FFS risk scores in the calculation, without excluding any years of FFS risk scores, while making reasonable projections of what the actual average FFS risk score will be in the payment year.

Proposed CY 2025 Normalization Methodology for CMS-HCC Risk Adjustment Models:

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

Below is a description of the multiple linear regression methodology that we propose to use for calculating CY 2025 normalization factors for the CMS-HCC models, followed by an example of the calculation of the proposed CY 2025 normalization factor for the 2024 CMS-HCC risk adjustment model under the multiple linear regression methodology.

The multiple linear regression equation is:

$$Y = \beta_0 + \beta_1 x_1 + \beta_2 x_2$$

The variables in the multiple linear regression equation for the CY 2025 normalization factors are:

Y = Predicted FFS risk score for a given year (i.e., Normalization Factor)
β_0 = Intercept
β_1 = Regression coefficient for the average annual change in FFS risk scores
x_1 = The specific year to be predicted
β_2 = Regression coefficient for the impact of the COVID-19 pandemic on FFS risk scores
x_2 = COVID-19 flag (0 for years before CY 2021, 1 for CY 2021 and onwards)

Using the historical average FFS risk scores from 2019-2023 and the corresponding flag for years before and after the onset of the COVID-19 pandemic, CMS used multiple linear regression to calculate regression coefficients for β_0 (intercept), β_1 (average annual change in FFS risk scores), and β_2 (impact of the COVID-19 pandemic on FFS risk scores), the outputs of the multiple linear regression model. The regression coefficients are model specific and are constants. CMS used the model-specific regression coefficients, rounded to the fourth decimal place, to calculate the CY 2025 normalization factor for each CMS-HCC risk adjustment model.

As an example, for the 2024 CMS-HCC risk adjustment model, CMS calculated the regression coefficients using the 2019 to 2023 average FFS risk scores from Table II-10 and the appropriate COVID-19 flag for the year. CMS then used these regression coefficients (listed in Table II-11)

to calculate the CY 2025 proposed normalization factor as follows, rounding to the third decimal place at the end of the calculation:

$\beta_0 = -36.1638$
$\beta_1 = 0.0184$
$x_1 = 2025$
$\beta_2 = -0.0513$
$x_2 = 1$
$Y = -36.1638 + (0.0184 * 2025) + (-0.0513 * 1)$
$Y = 1.0449$
CY 2025 Normalization Factor = 1.045

The proposed methodology adjusts for the impact of the COVID-19 pandemic on the FFS risk score trend by including the COVID-19 flag, and 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. Under the historical methodology, the risk scores are fit to a linear slope and the projection of the slope from the denominator year to the payment year treats each year uniformly. This means that the linear slope method predicts growth for each year from the denominator year (when risk scores were 1.0) to the payment year using the same growth factor over the entire period, based on the calculated slope. Due to this, the historical approach is vulnerable to significant changes in the trend, as was observed during the COVID-19 pandemic where risk scores dropped significantly due to atypically low utilization, and the linear slope method is unable to intrinsically take into account the impact of the COVID-19 pandemic. A multiple linear regression methodology, on the other hand, can take into account the drop in the average FFS risk score due to COVID-19 and calculates the slope independent from the anomalous 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 projections. As a result, a multiple linear regression methodology allows for a more dynamic methodology that includes adjustments to recognize the impact of the pandemic and to account for how post-COVID-19 pandemic risk scores are growing at a rate that is different than the growth of risk scores prior to the COVID-19 pandemic. Rather than calculating a linear slope using five years of historical data and projecting out from the denominator year as we did under the historical methodology, the proposed methodology considers the distinct trends and risk score levels for the pre- and post-COVID-19 periods when projecting to the future year.

CMS assessed the proposed methodology using the 2024 CMS-HCC model to determine whether it allows us to include more recent data years while projecting a reasonable normalization factor that is representative of what the average FFS risk score is likely to be in CY 2025 given the currently available data. Now that we have the 2023 average FFS risk score

to better understand the post-COVID-19 pandemic FFS risk score trend, we believe this proposed approach is an accurate reflection.

Using the coefficients from the proposed multiple linear regression methodology in Table II-11 we calculated risk scores back to 2019 using the 2024 CMS-HCC risk adjustment model and observe that the proposed method is a good fit to the actual average FFS risk score data. Under the proposed method we are able to reasonably reflect the underlying patterns in the historical FFS risk scores in both pre-and post-COVID-19 periods. Additionally, with the 2023 FFS risk score now available, we now have two years of average FFS risk scores after 2021, when the risk score dropped due to the COVID-19 pandemic. For CY 2024, when only one year of data after 2021 was available, it was unclear how the growth observed from 2021 to 2022 would change in future years. We can now observe that average FFS risk scores grew faster than what we could ascertain when the most recent average FFS risk score was 2022.

As stated in the CY 2024 Advance Notice, 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 believes that this approach is the best way to more reasonably normalize, given the variability in the years affected by COVID-19. We encourage feedback on all normalization calculation approaches, including both the linear slope and multiple linear regression approaches, and how they serve our goal of effective normalization and payment accuracy.

CMS-HCC Model Normalization Factors Proposal: The proposed normalization factors using the multiple linear regression methodology and the multiple linear regression coefficients for each of the CMS-HCC risk adjustment models are in subsections K1 through K3.

K1. Normalization Factors for the Part C CMS-HCC Models

The trends for the Part C models are calculated using FFS beneficiaries who are entitled to Part A, enrolled in Part B, who do not have ESRD, and are not in hospice status. The normalization factors for the Part C CMS-HCC risk adjustment models are applied to the community non-dual aged, community non-dual disabled, community full benefit dual aged, community full benefit dual disabled, community partial benefit dual aged, community partial benefit dual disabled, institutional, new enrollee, and C-SNP new enrollee risk scores.

Table II-10 shows the average FFS risk scores calculated for years 2016 through 2023 using the 2017, 2020, and 2024 Part C CMS-HCC risk adjustment models and Table II-11 shows the regression coefficients that were used to calculate the proposed CY 2025 normalization factors for each of the three Part C CMS-HCC risk adjustment models.

2024 Part C CMS-HCC Model: The proposed 2025 normalization factor calculated using the multiple linear regression method and 2019-2023 average FFS risk scores for the 2024 CMS-HCC risk adjustment model that we are proposing to further phase in for CY 2025 is 1.045.

2020 Part C CMS-HCC Model: The proposed 2025 normalization factor calculated using the multiple linear regression method and 2019-2023 average FFS risk scores for the 2020 CMS-HCC risk adjustment model that we are proposing to further phase out for CY 2025 is 1.153.

2017 Part C CMS-HCC Model: The proposed 2025 normalization factor calculated using the multiple linear regression method and 2019-2023 average FFS risk scores for the 2017 CMS-HCC risk adjustment model used for PACE organizations is 1.157.

Table II-10. Average FFS Risk Scores for Part C CMS-HCC Models

Year	2024 CMS-HCC Model	2020 CMS-HCC Model	2017 CMS-HCC Model
2016	-[39]	1.020	1.020
2017	0.969	1.031	1.034
2018	0.980	1.049	1.053
2019	0.990	1.064	1.069
2020	1.000	1.079	1.085
2021	0.968	1.048	1.053
2022	0.992	1.079	1.084
2023	1.009	1.104	1.108

Table II-11. Part C CMS-HCC Model Normalization Factor Regression Coefficients

Coefficient	2024 CMS-HCC Model	2020 CMS-HCC Model	2017 CMS-HCC Model
Intercept (β_0)	-36.1638	-50.2238	-49.8144
Average Change in FFS Risk Scores (β_1)	0.0184	0.0254	0.0252
COVID-19 Flag (β_2)	-0.0513	-0.0580	-0.0583

K2. Normalization Factors for the ESRD Dialysis CMS-HCC Models

The trends for the ESRD Dialysis models are calculated using FFS beneficiaries who are entitled to Part A, enrolled in Part B, are not in hospice status, and are receiving dialysis treatment. The

[39] The 2016 FFS risk score is not available for the 2024 CMS-HCC model because CMS does not have ICD-9 codes mapped to this model's ICD-10 based HCCs. The diagnoses used to calculate 2016 risk scores are from 2015, when the ICD-9 classification system was in use.

normalization factors for the ESRD Dialysis CMS-HCC models are applied to the risk scores for enrollees in the dialysis, dialysis new enrollee, and transplant segments.

Table II-12 shows the average FFS risk scores calculated for years 2016 through 2023 using the 2019 and 2023 ESRD Dialysis CMS-HCC risk adjustment models and Table II-13 shows the regression coefficients that were used to calculate the proposed CY 2025 normalization factors for both ESRD Dialysis CMS-HCC models.

2023 ESRD Dialysis CMS-HCC Model: The proposed 2025 normalization factor calculated using the multiple linear regression method and 2019-2023 average FFS risk scores for the 2023 ESRD dialysis model is 1.044.

2019 ESRD Dialysis CMS-HCC Model: The proposed 2025 normalization factor calculated using the multiple linear regression method and 2019-2023 average FFS risk scores for the 2019 ESRD dialysis model used for PACE organizations is 1.103.

Table II-12. Average FFS Risk Scores for ESRD Dialysis CMS-HCC Models

Year	2023 ESRD Dialysis Model	2019 ESRD Dialysis Model
2016	0.974	1.016
2017	0.983	1.029
2018	0.991	1.042
2019	1.000	1.053
2020	1.006	1.057
2021	0.997	1.047
2022	1.006	1.061
2023	1.023	1.079

Table II-13. ESRD Dialysis Model Normalization Factor Regression Coefficients

Coefficient	2023 ESRD Dialysis Model	2019 ESRD Dialysis Model
Intercept (β_0)	-22.4232	-26.4102
Average Change in FFS Risk Scores (β_1)	0.0116	0.0136
COVID-19 Flag (β_2)	-0.0233	-0.0267

K3. Normalization Factors for the ESRD Functioning Graft CMS-HCC Models

The trends for the ESRD functioning graft models are calculated using FFS beneficiaries who are entitled to Part A, enrolled in Part B, do not have ESRD, and are not in hospice status. The normalization factors for the ESRD functioning graft models are applied to the risk scores for enrollees in the functioning graft community, functioning graft institutional, and functioning graft new enrollee segments.

Table II-14 shows the average FFS risk scores calculated for years 2016 through 2023 using the 2019 and 2023 ESRD Functioning Graft CMS-HCC risk adjustment models and Table II-15 shows the regression coefficients that were used to calculate the proposed CY 2025 normalization factors for both ESRD Functioning Graft CMS-HCC models.

2023 ESRD Functioning Graft Model: The proposed 2025 normalization factor calculated using the multiple linear regression method and 2019-2023 average FFS risk scores for the 2023 ESRD Functioning Graft model is 1.074.

2019 ESRD Functioning Graft Model: The proposed 2025 normalization factor calculated using the multiple linear regression method and 2019-2023 average FFS risk scores for the 2019 ESRD Functioning Graft model used for PACE organizations is 1.159.

Table II-14. Average FFS Risk Scores for ESRD Functioning Graft CMS-HCC Models

Year	2023 ESRD Functioning Graft Model	2019 ESRD Functioning Graft Model
2016	0.966	1.024
2017	0.973	1.039
2018	0.987	1.059
2019	1.000	1.074
2020	1.011	1.088
2021	0.976	1.054
2022	1.006	1.086
2023	1.029	1.110

Table II-15. ESRD Functioning Graft Model Normalization Factor Regression Coefficients

Coefficient	2023 ESRD Functioning Graft Model	2019 ESRD Functioning Graft Model
Intercept (β_0)	-46.2508	-49.8104
Average Change in FFS Risk Scores (β_1)	0.0234	0.0252
COVID-19 Flag (β_2)	-0.0603	-0.0607

For information on the Part D model normalization factors, please see Attachment III Section H.

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

Non-PACE

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

L1. Sources of Diagnoses for Risk Score Calculation for CY 2025 PACE

For PACE organizations, for CY 2025, we will continue using the same method of calculating risk scores under the CMS-HCC and ESRD 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) Risk Adjustment Processing System (RAPS) data, and (3) FFS claims.

In recent years CMS has received comments in response to Advance Notices,[40] and through other engagements with stakeholders, recommending that CMS align PACE with the MA program with respect to the use of a more recent version of the CMS-HCC model to calculate risk scores. CMS acknowledges the concerns raised by PACE organizations and shares in the desire to align PACE with the MA program on the new CMS-HCC model, which entails fully transitioning PACE organizations to encounter data-based risk scores. As CMS has noted in response to previous comments from PACE organizations, fulsome encounter data submissions are necessary for moving to an updated version of the CMS-HCC model because more recent versions of the CMS-HCC model have been calibrated using the CPT/ HCPCS-based filtering

[40] Refer to the 2023 & 2024 Announcement: https://www.cms.gov/Medicare/Health-Plans/MedicareAdvtgSpecRateStats/Announcements-and-Documents.

methodology for diagnoses submitted through encounter data,[41] and the diagnosis filtering used to calculate risk scores needs to align with the diagnosis filtering used to calibrate a model for payments to be appropriate.

Historically, the identification and submission of risk-adjustment-eligible diagnoses to the RAPS for risk score calculation have been done by MA organizations and other submitters, such as PACE organizations. Starting in 2012, MA organizations and other submitters (except for PACE) began submitting encounter data. In November 2013, CMS released an HPMS memo titled, "Clarification to Encounter Data Submissions Memo for PACE Organizations," clarifying that PACE organizations are only required to submit encounter data records for services for which the organization collects claims. Because PACE organizations are only required to submit a subset of encounter data records in circumstances where they have a claim for a service, we do not have a complete diagnostic profile for PACE participants in the encounter data. Without a complete diagnostic profile, we cannot rely solely on encounter data to calculate PACE risk scores. Therefore, PACE organizations submit diagnoses to RAPS and encounter data (when applicable). In order to move PACE organizations to risk scores calculated using the updated risk adjustment model, risk adjustment eligible diagnoses must be pulled from the encounter data system (EDS) based on the uniformly applied CPT/HCPCS filtering methodology.[42]

Consequently, CMS is working with PACE organizations to fully transition from RAPS to the EDS so that the EDS can be the source of risk adjustment data for PACE. In 2022, CMS began engaging with some PACE organizations to discuss successes and challenges they have experienced with submitting encounter data. In addition, CMS conducted an encounter data technical user group call for PACE organizations.[43] In the CY 2024 Rate Announcement,[44] we noted our intention to conduct analyses to assess the state of encounter data submissions for PACE organizations. In addition, stated our commitment to continuing to work closely with PACE organizations to develop further guidance and provide technical assistance with transitioning PACE organizations fully to encounter data in anticipation of future implementation of a more recent version of the CMS-HCC risk adjustment model for PACE that is calibrated using encounter data. As a result 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

[41] The most recent versions of the CMS-HCC model (i.e., 2020 CMS-HCC model and 2024 CMS-HCC model) were calibrated using the CPT/HCPCS-based filtering logic used for encounter data. Refer to the 2020 and 2024 Advance Notices and Rate Announcements and the Final Encounter Data Diagnosis Filtering Logic HPMS Memo.

[42] Final Encounter Data Diagnosis Filtering Logic

[43] On April 7, 2022, CMS conducted a user group call to provide background on the encounter data format, encounter data processing, and filtering for risk adjustment eligible diagnoses, as well as encounter data reports.

[44] Refer to Section J. of the 2024 Rate Announcement: https://www.cms.gov/files/document/2024-announcement-pdf.pdf

updated risk adjustment model for PACE. We intend to provide ample support and guidance to make this transition as straightforward as possible. To that end, we intend to release technical operational submission guidance to begin transitioning PACE organizations to EDS submission in the coming months.

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

Attachment III proposes revisions to the RxHCC risk adjustment model and provides updates to the Part D benefit parameters for CY 2025. CMS annually updates the Part D benefit parameters and we provide the CY 2025 updates to these parameters in Sections A though F. We discuss the proposed revised RxHCC Risk Adjustment Model used to adjust direct subsidy payments for Part D benefits offered by PDPs and MA-PDs in Section G, the normalization factors for the proposed RxHCC models in Section H, and information on the sources of diagnoses for the Part D risk score calculation in Section I.

Each year in the Advance Notice, CMS updates the statutory parameters for the defined standard Part D drug benefit and provides information on any changes to the payment methodology for the Part D benefit.

In order to ensure that the actuarial value of the Part D drug benefit remains consistent with changes in Part D drug expenses, certain parameters are updated using one of two indexing methods: the annual percentage increase in average expenditures for Part D drugs per eligible beneficiary (API) or the annual percentage increase in the Consumer Price Index (CPI) (all items, U.S. city average). In CY 2025, some benefit parameters will also be updated or eliminated because of amendments to the Act made by the Inflation Reduction Act (IRA).

In Section A1, CMS provides the API and CPI for 2025, identifies those parameters updated or eliminated by statute, and provides tables outlining the benefit parameters for the standard benefit as well as for low-income subsidy (LIS) beneficiaries. In Section A2, CMS explains the calculation methodologies for the API and CPI. In Section A3, CMS describes the benefit parameters updated in this notice and provides additional tables with information on the updated parameters for both LIS and non-LIS beneficiaries.[45]

In Sections B through F, CMS describes other updates relevant to the Part D benefit parameters for 2025, including the sunsetting of the Coverage Gap Discount Program (CGDP) and establishment of a new Manufacturer Discount Program (Discount Program), Part D premium stabilization, the prospective reinsurance amount for CY Employer Group Waiver Plans (EGWPs), retiree drug subsidy amounts, and Part D risk sharing.

[45] Historically, CMS has used the term "applicable beneficiary," as defined in section 1860D-14A(g)(1) of the Act and § 423.100, to refer to a non-LIS beneficiary enrolled in a stand-alone prescription drug plan or Medicare Advantage prescription drug plan and who is not enrolled in a retiree prescription drug plan, and the term "non-applicable beneficiary" to refer to an LIS beneficiary. As noted below, the CGDP sunsets effective January 1, 2025, and is replaced by the new Discount Program. Both LIS and non-LIS beneficiaries are included in the definition of applicable beneficiary under the Discount Program. Therefore, the terms "applicable beneficiary" and "non-applicable beneficiary" are no longer useful for describing how the benefit parameters discussed in the Advance Notice apply to LIS and non-LIS beneficiaries and will no longer be used to distinguish between LIS and non-LIS beneficiaries.

In addition, CMS provides information on proposed updates to the RxHCC risk adjustment model used to adjust direct subsidy payments for Part D benefits offered by PDPs and MA-PDs in Section G, the normalization factors for the proposed RxHCC models in Section H, and information on the sources of diagnoses for the Part D risk score calculation in Section I.

As noted earlier in this document, the IRA made several amendments and additions to the Act that affect the structure of the defined standard Part D drug benefit for CY 2023 and subsequent years. CMS is releasing separate Draft CY 2025 Part D Redesign Program Instructions concurrently with this document that will describe those changes in detail and provide guidance on changes in place for 2025. For reference purposes, we are also including a list of certain IRA provisions in place for 2025 here.

IRA provisions in effect for CY 2025 include:

- Beginning in CY 2025, the coverage gap phase will be eliminated and defined standard Part D prescription drug coverage will consist of a three-phase benefit. As such, there will be no initial coverage limit and the initial coverage phase will extend to the maximum annual OOP threshold, at which point the catastrophic phase will begin.
- The annual OOP threshold is statutorily set at $2,000 for CY 2025 rather than updated using the API.
- As in CY 2024, there is no beneficiary cost sharing above the annual OOP threshold in CY 2025.
- The CGDP sunsets effective January 1, 2025, and is replaced by the Discount Program. Under the Discount Program, the manufacturer will typically pay a 10 percent discount for applicable drugs in the initial coverage phase.[46] In the catastrophic phase, manufacturers will typically pay a 20 percent discount for applicable drugs. In certain circumstances, manufacturer discounts will be phased in and may be less than 10 percent in the initial coverage phase and 20 percent in the catastrophic coverage phase.
- The reinsurance payment amount for CY 2025 for a Part D beneficiary will decrease from 80 percent of the allowable reinsurance costs incurred after the beneficiary exceeds

[46] As defined at section 1860D-14C(g)(2) of the Act and in section 40.1 of the Medicare Part D Manufacturer Discount Program Final Guidance, applicable drugs under the Discount Program are all Part D drugs approved under a new drug application under section 505(c) of the Federal Food, Drug, and Cosmetic Act (FDCA) or, in the case of a biologic product, licensed under section 351 of the Public Health Service Act (PHSA), other than a selected drug (as referred to under section 1192(c) of the Act) dispensed during a price applicability period (as defined in section 1191(b)(2) of the Act). Because the statute defines in part an applicable drug as a Part D drug that is approved under an NDA under section 505(c) of the FDCA or is licensed under section 351 of the PHSA, a Part D drug that meets such criteria will be considered an applicable drug regardless of whether the plan sponsor treats such product as a brand name or generic product under its benefit. *See* Medicare Part D Manufacturer Discount Program Final Guidance (November 17, 2023). https://www.cms.gov/files/document/manufacturer-discount-program-final-guidance.pdf.

the annual OOP threshold to 20 percent for applicable drugs or 40 percent for non-applicable drugs.

- Beginning in CY 2025, the definition of incurred costs at section 1860D-2(b)(4)(C) of the Act will be updated to include, among other categories of costs, supplemental coverage and other health insurance, which was previously excluded from the definition of incurred costs. Manufacturer discounts provided under the Discount Program will be excluded from the definition of incurred costs.
- Premium stabilization will continue to be in effect, and the base beneficiary premium (BBP) in CY 2025 will be the lesser of the CY 2024 BBP increased by 6 percent or the BBP as it would have been calculated if the IRA's premium stabilization provision had not been enacted.

Only those IRA policies that directly affect the CY 2025 statutory parameters for the defined standard Part D drug benefit are discussed in Attachment III below. Please see the Draft CY 2025 Part D Redesign Program Instructions for additional information on IRA-related changes.

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

Certain parameters are annually updated using one of two indexing methods, the API or the CPI, to ensure that the actuarial value of the benefit remains consistent with changes in Part D drug expenditures. Beginning in CY 2023, the IRA exempted from the deductible and eliminated beneficiary cost sharing for ACIP-recommended adult vaccines and exempted from the deductible and established a $35 maximum copayment amount for a one-month supply of each covered insulin product. Beginning in CY 2024, beneficiary cost sharing in the catastrophic phase of the benefit was eliminated. Beginning in CY 2025, the IRA eliminates the coverage gap phase and, for CY 2025, sets the annual OOP threshold at $2,000.

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

- **Annual deductible:** Beneficiaries will be responsible for all of their Part D prescription drug costs until they reach the defined standard deductible limit, with the exception that the deductible will continue to not apply to any Part D covered insulin product and any ACIP-recommended adult vaccine. The defined standard Part D deductible will be updated using the API for 2025.
- **Initial coverage phase:** In the initial coverage phase, the beneficiary pays 25% coinsurance for most covered Part D drugs.[47] Because the coverage gap phase is eliminated beginning in CY 2025, there will not be an initial coverage limit, and, thus,

[47] The exceptions include ACIP-recommended adult vaccines, for which beneficiaries pay $0, and covered insulin products, for which the cost sharing in the initial coverage phase is eliminated and capped at $35/month.

that parameter will no longer be updated. The initial coverage phase will extend to the maximum annual OOP threshold. The annual OOP threshold for CY 2025 has been set at $2,000 by statute and will not be updated using the API for CY 2025.

- **Catastrophic coverage phase:** Beneficiaries will continue to pay no cost sharing for covered Part D drugs in the catastrophic coverage phase. Therefore, beneficiary cost sharing above the annual OOP threshold will no longer be updated.

Please see the Draft CY 2025 Part D Redesign Program Instructions published concurrently with this Advance Notice for a detailed description of IRA-related changes to the Part D benefit which take effect in CY 2025 and guidance related to those changes, including a discussion of how beneficiaries will progress through the defined standard Part D benefit phases and which costs will count toward TrOOP in CY 2025. IRA changes specific to CY 2023 were described in separate guidance specific to CY 2023.[48] IRA changes specific to CY 2024 were described in the CY 2024 Rate Announcement.

A1. Updating the Medicare Part D Benefit Parameters

Section 1860D-1 *et seq.* of the Act directs CMS to update the statutory parameters for the defined standard Part D drug benefit each year. These annual adjustments ensure that the actuarial value of the drug benefit remains consistent with changes in Part D drug expenses. This section provides the methodologies used to update the statutory parameters for CY 2025.

Historically, the statutory parameters have included the defined standard benefit deductible, initial coverage limit, and annual OOP threshold. In addition, CMS is required by statute to update the parameters for the LIS benefit. Given the changes enacted by the IRA, for CY 2025, only the defined standard benefit deductible and LIS benefit parameters will be updated per the methodology provided by the Act.

In addition, as stated in the CY 2024 Advance Notice, beneficiaries with incomes between 135 and 150 percent of the FPL, who meet the resource standard described at 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, are eligible for the full LIS benefit in CY 2025. Beneficiaries who previously met the resource requirement for category 4 will now be in category 1 in CY 2025. Category 2 and 3 of the LIS remain unchanged. See the discussion of these categories in this section below.

[48] Centers for Medicare & Medicaid Services, Contract Year 2023 Program Guidance Related to Inflation Reduction Act Changes to Part D Coverage of Vaccines and Insulin (Sept. 26, 2022). https://www.cms.gov/httpseditcmsgovresearch-statistics-data-and-systemscomputer-data-andsystemshpmshpms-memos-archive/hpms-memos-wk-5-september-26-30.

Also, as noted above, section 11201 of the IRA amends section 1860D-2(b)(4)(B) of the Act to set the annual OOP threshold at $2,000 for CY 2025. Therefore, the methodology that we normally apply to update the annual OOP threshold each year is not applicable for CY 2025. Starting in CY 2026, the IRA requires that CMS resume updating the annual OOP threshold using that methodology.

Finally, it is not necessary to update the parameters for maximum or minimum beneficiary cost sharing in the coverage gap or above the annual OOP threshold for CY 2025 as the coverage gap phase and beneficiary cost sharing above the annual OOP threshold have been eliminated.

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

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." As noted above, in CY 2025, the only defined standard Part D prescription drug benefit parameter that is updated using the API is the deductible. However, while the annual OOP threshold is set at $2,000 by statute for CY 2025, it will be updated using the API starting in CY 2026. The only LIS cost-sharing parameter that is updated using the API is the maximum copayment below the annual OOP threshold for low-income, full-subsidy-eligible beneficiaries with incomes between 100 and 150 percent of the FPL.

The CY 2024 annual percentage trend in the API can be found in Table III-1 below. The percent increase in the benefit parameters indexed to the API for CY 2025 is 8.58 percent. This increase reflects the CY 2024 annual percentage trend of 5.46 percent in the API as well as a multiplicative update of 2.96 percent for prior year revisions. See Section A2 for additional information on the calculation of the API.

Annual Percentage Increase in Consumer Price Index, 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. CMS uses an estimate of the September 2024 CPI based on projections from the President's FY 2025 Budget for this purpose.

The CY 2024 annual percentage trend in the CPI can be found in Table III-1 below. The percent increase in the maximum copayments indexed to the CPI for CY 2025 is 2.50 percent. The CY

2025 increase reflects the CY 2024 annual percentage trend in the CPI of 2.61 percent as well as a multiplicative update of -0.11 percent for prior year revisions.

See Section A2 for additional information on the calculation of the annual percentage increase in the CPI.

Table III-1. Updated API and CPI for CY 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 III-2 below summarizes the Part D benefit parameters discussed in this notice, including those that are required by statute to be updated with either the API or CPI each year. The 2024 column shows the CY 2024 values for the Part D benefit parameters. The 2025 column shows the updated parameters for CY 2025. The CY 2025 values will be updated using either the CY 2025 API of 8.58 percent or CPI of 2.50 percent, as applicable.

Both the CY 2024 and CY 2025 parameters reflect the elimination of beneficiary cost sharing above the annual OOP threshold for all Part D beneficiaries regardless of their LIS status. The CY 2025 parameters also reflect the elimination of the coverage gap phase and the statutorily set annual OOP threshold of $2,000 for CY 2025, consistent with the amendments to the Act made by section 11201 of the IRA. We also provide the Part D benefit parameters that remain constant from year-to-year.

For completeness, Table III-2 also includes estimates of the cost threshold and cost limit for the Retiree Drug Subsidy program (discussed in more detail in Section F).

Table III-2. Updated Part D Benefit Parameters for Defined Standard Benefit, Low-Income Subsidy, and Retiree Drug Subsidy

	2024	2025[49]
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% 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
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:

[49] 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.

- Category Code 1 – Non-institutionalized FBDE beneficiaries with incomes between 100% and 150% of FPL and full-subsidy-non-FBDE beneficiaries.
- Category Code 2 – Non-institutionalized FBDE beneficiaries with incomes up to 100% 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 – As described above, 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.

A2. Calculation methodologies for the Annual Percentage Increase (API) and Consumer Price Index (CPI)

As noted above, the API and CPI are indexing methods used to update certain Part D benefit parameters. This section describes in detail the calculation methodologies used to determine the API and CPI for 2025.

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

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 annual percentage trend in table III-3 is based on updated NHE prescription drug per capita costs and PDE data. The years in this table refer to the trend observed in the period of the August of the prior year to July of that year relative to the same interval in preceding years. For example, year 2021 represents the trend observed in August 2020 to July 2021 relative to August 2019 to July 2020.

Table III-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%

Year	Prior Estimates of Annual Percentage Trend	Revised Annual Percentage Trend
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 will reflect the CY 2024 annual percentage trend and a multiplicative update for prior year revisions. The CY 2024 annual percentage trend can be found in Table III-4. The CY 2024 API are updated by 2.96 percent.

Table III-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) Calculation Methodology

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 2024 value is from the Bureau of Labor Statistics. The annual percentage trend in the September CPI for CY 2025 is calculated as follows:

$$\frac{Projected\ September\ 2024\ CPI}{Actual\ September\ 2023\ CPI}$$ 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 III-5 below.

Table III-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.

A3. Annual Adjustments for Part D Benefit Parameters in CY 2025

Defined Standard Part D Prescription Drug Benefit Parameters

In accordance with section 1860D-2(b) of the Act, CMS updates the statutory parameters for the defined standard Part D prescription drug benefit each year. As mentioned previously, these annual adjustments ensure that the actuarial value of the drug benefit remains consistent with changes in Part D drug expenses. As noted above, the IRA also made several amendments and additions to the Act that affect the structure of the defined standard Part D prescription drug benefit in CY 2025, which are reflected in the discussion below.

As described in section 1860D-2(b) of the Act, as amended by section 11201 of the IRA, beginning in CY 2025, the defined standard Part D prescription drug benefit is composed of three sequential coverage phases: deductible, initial coverage, and catastrophic coverage phases. Under section 1860D-2(b) and (c) of the Act, as amended by section 11201 of the IRA, the coverage gap phase has been eliminated in CY 2025, meaning a beneficiary will leave the initial coverage phase and enter the catastrophic phase once they incur enough TrOOP-eligible costs to meet the annual OOP threshold, which is $2,000 in CY 2025. TrOOP is spending on covered Part D drugs by the beneficiary or on their behalf by certain third parties. As noted above, the categories of payments that count toward TrOOP will change in CY 2025. Specifically, TrOOP will include previously excluded supplemental benefits and exclude Discount Program payments (*see* sections 1860D-2(b)(4)(C)(iii) and (F) of the Act). For information on how beneficiaries will progress through the defined standard Part D benefit phases and which costs will count toward TrOOP in CY 2025, please see the Draft CY 2025 Part D Redesign Program Instructions published concurrently with this document.

Cost sharing for beneficiaries varies by coverage phase, by LIS status, and whether the drug is a covered insulin product or ACIP-recommended adult vaccine. See Table III-6 below for non-LIS beneficiary cost sharing and the next section for discussion of cost-sharing requirements for LIS beneficiaries.

For CY 2025, the defined standard benefit deductible amount is updated by multiplying the CY 2024 amount of $545 by the CY 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 III-6 below summarizes the defined standard benefit parameters and provides the CY 2024 parameter values. The updated parameter values for CY 2025 are obtained by applying the 2025 API and rounding to a specified amount and are summarized in Table III-6. Table III-6 also shows the elimination of the coverage gap for CY 2025 and cost sharing above the annual OOP threshold for CY 2024 for all Part D beneficiaries regardless of their LIS status, as well as the $2,000 annual OOP threshold set by statute for CY 2025, consistent with the amendments to the Act made by section 11201 of the IRA.

Table III-6. Part D Benefit Parameters for Defined Standard Benefit for CY 2024 and CY 2025 for Non-LIS Beneficiaries[50]

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

Annual Adjustments for Low-Income Subsidy (LIS) Beneficiary Cost-Sharing Parameters

The LIS benefit provides Part D cost-sharing assistance to certain low-income Medicare Part D beneficiaries across the same coverage phases described above. Medicare Part D beneficiaries who are eligible for full Medicaid benefits, recipients of Supplemental Security Income (SSI)

[50] 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.

benefits (*see* § 423.773(c)(1)(ii)), or eligible for a Medicare Savings Programs as a Qualified Medicare Beneficiary (QMB), Specified Low-income Medicare Beneficiary (SLMB), or Qualifying Individual under a State's Medicaid plan (*see* § 423.773(c)(1)(iii)) are deemed automatically eligible for the full subsidy and do not have to separately apply for the LIS benefit. Other Medicare Part D beneficiaries must apply for the LIS benefit and may receive the full subsidy if they meet certain income and asset requirements, as described in section 1860D-14(a)(3)(E) of the Act.

The cost-sharing benefits for LIS beneficiaries are described in section 1860D-14(a)(1) of the Act. Full subsidy FBDE individuals who are institutionalized or receiving certain home and community-based services, as defined in § 423.772, have a $0 deductible and $0 copayments for all covered Part D drugs, regardless of the defined standard benefit phase. Other full subsidy (both FBDE and non-FBDE) beneficiaries also have a $0 deductible but pay nominal copayments for all covered Part D drugs below the annual OOP threshold as described in sections 1860D-14(a)(1)(D)(ii) and (iii).

As noted in the CY 2024 Advance Notice, beneficiaries with incomes between 135 and 150 percent of the FPL, who meet the statutory resource standards at either of sections 1860D-14(a)(3)(D) or (E) and who would have been eligible for the partial LIS benefit absent the enactment of the IRA, are eligible for the full LIS benefit in CY 2025.

The following LIS cost-sharing parameters are updated each year by multiplying the prior year's value by the API and rounding as specified by the statute:

Maximum Copayments up to the Annual OOP Threshold for Certain Low-Income Full Subsidy Eligible Beneficiaries: From $4.50 per generic, preferred drug that is a multi-source drug, or biosimilar and $11.20 for all other drugs in CY 2024, rounded to the nearest multiple of $0.05.

Maximum Copayment Amounts up to the Annual OOP Threshold for Full Benefit Dual Eligible Beneficiaries with Incomes Not Exceeding 100 Percent of the Federal Poverty Level: 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.[51]

Please see Table III-7 below for complete information on the different LIS benefit categories and cost-sharing parameters for CY 2024, as well as the LIS cost-sharing parameters updated for CY 2025 by either using the 2025 API or CPI. Table III-7 also shows the elimination of the coverage

[51] 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.

gap for CY 2025 and cost sharing above the annual OOP threshold for CY 2024 for all Part D beneficiaries regardless of their LIS status, as well as the statutory establishment of a $2,000 annual OOP threshold for CY 2025, consistent with the amendments to the Act made by section 11201 of the IRA.

Table III-7. Updated Part D Low-income Cost-Sharing Parameters for CY 2025[52]

	2024	2025
Full Subsidy-Full Benefit Dual Eligible (FBDE) Beneficiaries (1)		
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] (2)	$0.00	$0.00
Maximum Copayments for Non-Institutionalized Beneficiaries		
Up to or at 100% FPL [category code 2]		
Up to Out-of-Pocket Threshold		
Generic/Preferred Multi-Source Drug (3)	$1.55	$1.60
Other (3)	$4.60	$4.80
Between 100% and 150% of FPL		
Up to Out-of-Pocket Threshold		
Generic/Preferred Multi-Source Drug	$4.50	$4.90
Other	$11.20	$12.15
Full Subsidy-Non-FBDE Beneficiaries (1)		
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 (couple, 2024) [category code 1] (4)		
Deductible		
Maximum Copayments up to Out-of-Pocket Threshold		
Generic/Preferred Multi-Source Drug	$4.50	$4.90
Other	$11.20	$12.15

(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 and 150 percent of FPL who meet the statutory resource requirements, and full-subsidy-non-FBDE beneficiaries.

[52] 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.

- Category Code 2 – Non-institutionalized FBDE beneficiaries with incomes up to 100 percent of the FPL and who meet the statutory resource requirements.
- 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 – As described in the 2024 Advance Notice, beneficiaries with incomes between 135 and 150 percent of the FPL who meet the resource standards under either of sections 1860D-14(a)(3) (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 premium and a $0 deductible. 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 individual (or couple) would have been institutionalized.

(3) Increases to the maximum copayments for non-institutionalized FBDE beneficiaries with incomes not greater than 100 percent of the FPL are applied to the unrounded CY 2024 values of $1.55 for generic/preferred multi-source drugs and $4.65 for all other drugs.

(4) 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 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). In addition, beneficiaries that would have been eligible for the partial LIS benefit had the IRA not been enacted are eligible for the full LIS benefit if they meet the resource standard described at section 1860D-14(a)(3)(E) of the Act.

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

Under section 1860D-14A(h) of the Act, as added by section 11201 of the IRA, the CGDP sunsets effective January 1, 2025. Under section 1860D-14C of the Act, as added by section 11201 of the IRA, the new Discount Program will replace the CGDP beginning in CY 2025. The new Discount Program requires manufacturers to provide discounts on applicable drugs in the initial coverage phase and catastrophic phase of the defined standard Part D drug benefit. The program applies to applicable drugs dispensed to both LIS and non-LIS beneficiaries.

Under the new Discount Program, the manufacturer will typically pay a 10 percent discount for applicable drugs in the initial coverage phase. In the catastrophic phase, manufacturers will

typically pay a 20 percent discount for applicable drugs. For CY 2025, manufacturers eligible for the "specified manufacturer" and "specified small manufacturer" phase-ins will pay a 1 percent discount in the initial coverage and catastrophic coverage phases for certain applicable drugs dispensed to certain beneficiaries.

Because the applicable discount and enrollee cost sharing are both calculated based on the negotiated price of the drug, the applicable discount will not affect the application of the standard 25 percent coinsurance under section 1860D-2(b)(2)(A) of the Act or the application of the copayment amount under section 1860D-2(b)(4)(A) of the Act unless, after the discount is applied to the negotiated price of the drug, the enrollee cost sharing would exceed the discounted price.

For additional details and guidance on the new Discount Program, including the Discount Program phase-ins, see the Medicare Part D Manufacturer Discount Program Final Guidance and the Medicare Part D Manufacturer Discount Program: Methodology for Identifying Specified Manufacturers and Specified Small Manufacturers released on November 17, 2023[53] and the Draft CY 2025 Part D Redesign Program Instructions[54] published concurrently with this Advance Notice.

Section C. Part D Premium Stabilization

As described in the 2024 Advance Notice and the July 31, 2023, HPMS memorandum, titled "Annual Release of Part D National Average Bid Amount and Other Part C & D Bid Information,"[55] under section 1860D-13 of the Act, as added by section 11201 of the IRA, the Base Beneficiary Premium (BBP) for CY 2024 through CY 2029 is equal to the lesser of the prior year's BBP increased by 6 percent, or the BBP as it would have been calculated if the IRA's premium stabilization provision had not been enacted.

Therefore, the BBP for CY 2025 will not be greater than CY 2024 BBP, which was $34.70 (as released in the July 31, 2023, HPMS memorandum) increased by 6%, or $36.78. We will provide more information on the BBP calculation for CY 2025 during the usual timeframe after CY 2025 bids have been submitted. Please note that the BBP is calculated at the national level and that premiums for individual plans may increase by more than 6%.

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[53] *See* Medicare Part D Manufacturer Discount Program Final Guidance (November 17, 2023). https://www.cms.gov/files/document/manufacturer-discount-program-final-guidance.pdf. Medicare Part D Manufacturer Discount Program: Methodology for Identifying Specified Manufacturers and Specified Small Manufacturers (November 17, 2023). https://www.cms.gov/files/document/manufacturer-discount-program-specified-and-specified-small-manufacturer-methodology.pdf.

[54] Please see the Draft CY 2025 Part D Redesign Program Instructions published concurrently with this Advance Notice.

[55] Annual Release of Part D National Average Monthly Bid Amount and Other Part C & D Bid Information.

It is important to note that the Part D premium stabilization policy impacts the direct subsidy payments for Part D benefits offered by PDPs and MA-PDs. CMS provides a capitated direct subsidy payment for each Part D beneficiary equal to the Part D plan's approved standardized bid, risk adjusted for the beneficiary's health status, and reduced by the plan's basic Part D premium, as defined at § 423.329. Consistent with CY 2024, the direct subsidy amount will change depending on the impact of premium stabilization on the BBP calculation and, thereby, a plan's basic Part D beneficiary premium. As a result, the portion of the plan's bid for basic Part D coverage not funded by basic Part D premiums will continue to be paid through the direct subsidy.

Section D. Part D Calendar Year EGWP Prospective Reinsurance Amount

In recent years, CMS has made prospective reinsurance payments to all Part D Calendar Year EGWP sponsors based on the average per member-per month (PMPM) actual (final) reinsurance amounts paid to Part D Calendar Year EGWP sponsors for the most recently reconciled payment year, which for CY 2025 would be CY 2022.

However, given that the reinsurance percentages and methodology are changing significantly in CY 2025, as discussed above and in the Draft CY 2025 Part D Redesign Program Instructions[56] published concurrently with this Advance Notice, the methodology used to calculate the prospective reinsurance payments to all Part D Calendar Year EGWP sponsors also needs to be updated. For additional information regarding the reinsurance and Calendar Year EGWP prospective reinsurance amount changes, please see the Draft CY 2025 Part D Redesign Program Instructions. As noted in the Draft CY 2025 Part D Redesign Program Instructions, CMS plans to announce the CY 2025 prospective reinsurance payment amount for Part D Calendar Year EGWPs with the annual release of the Part D National Average Bid Amount (NAMBA), Part D BPP, and related Part D bid information in the summer of 2024.

Section E. Part D Risk Sharing

The risk sharing payments provided by CMS limit Part D sponsors' exposure to unexpected drug expenses. Pursuant to 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 beginning in CY 2012. 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. While CMS

[56] Please see the Draft CY 2025 Part D Redesign Program Instructions published concurrently with this Advance Notice.

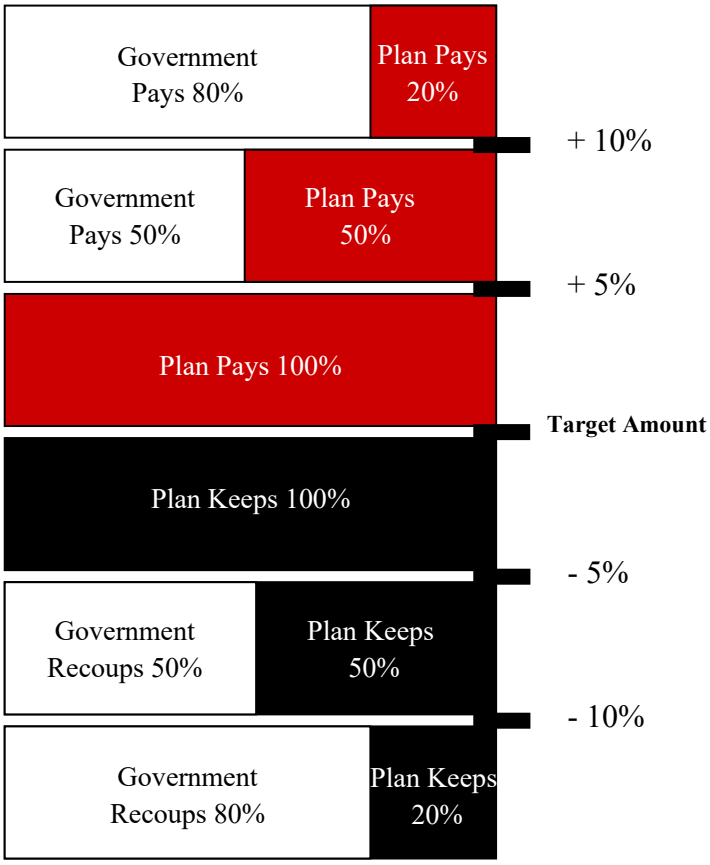
may widen the risk corridors, the statute does not permit CMS to narrow the corridors relative to the CY 2011 thresholds.

CMS has evaluated the risk sharing amounts for CYs 2008–2022 to assess whether they have decreased or stabilized. A steady decline or stabilization in the Part D risk sharing amounts would suggest that Part D sponsors have significantly improved their ability to predict Part D expenditures. However, CMS has found that risk sharing amounts continue to vary significantly in aggregate from year to year and among Part D sponsors in any given year. Although the benefit is changing for CY 2025, CMS is prohibited by statute from narrowing the risk corridors. We do not believe it is appropriate to adjust the parameters in the manner allowed by the statute at this time, and we will apply no changes to the current threshold risk percentages for CY 2025. We will continue to evaluate the risk sharing amounts each year to determine if wider corridors should be applied for Part D risk sharing.

Thus, the risk percentages and payment adjustments for Part D risk sharing are unchanged from CY 2024. The risk percentages for the first and second thresholds remain at +/- 5 percent and +/- 10 percent of the target amount, respectively, for CY 2025.[57] The payment adjustments for the first and second corridors are 50 percent and 80 percent, respectively. Figure III-1 below illustrates the risk corridors for CY 2025.

[57] Per section 1860D-15(e)(3)(B) of the Act, the target amount is the total amount of payments (from both CMS and by or on behalf of enrollees) to a Part D plan for the coverage year based on the standardized bid amount, less the administrative expenses assumed in the standardized bid.

Figure III-1. Part D Risk Corridors for CY 2025



E1. Risk sharing when a plan's adjusted allowable risk corridor costs (AARCC) exceed the target amount

For the portion of a plan's adjusted allowable risk corridor costs (AARCC[58]) that is between the target amount and the first threshold upper limit (105 percent of the target amount), the Part D sponsor pays 100 percent of this amount. For the portion of the plan's AARCC that is between the first threshold upper limit and the second threshold upper limit (110 percent of the target amount), the government pays 50 percent, and the plan pays 50 percent. For the portion of the plan's AARCC that exceeds the second threshold upper limit, the government pays 80 percent, and the plan pays 20 percent.

[58] Per § 423.336(a), the "adjusted allowable risk corridor costs" for a Part D plan are the allowable risk corridor costs for a Part D plan for the coverage year, reduced by the sum of the total reinsurance payments and total low-income cost-sharing subsidies paid to the sponsor of the Part D plan for the coverage year.

Example: If a plan's AARCC is $120 and its target amount is $100, the Part D sponsor and the government cover $9.50 and $10.50, respectively, of the $20 in unanticipated costs. The sponsor's responsibility is calculated as follows:

100% of ($105 − $100) + 50% of ($110 − $105) + 20% of ($120 − $110).

E2. Risk sharing when a plan's adjusted allowable risk corridor costs (AARCC) are below the target amount

If a plan's AARCC is between the target amount and the first threshold lower limit (95 percent of the target amount), the plan keeps 100 percent of the difference between the target amount and the plan's AARCC. If a plan's AARCC is between the first threshold lower limit and the second threshold lower limit (90 percent of the target amount), the government recoups 50 percent of the difference between the first threshold lower limit and the plan's AARCC. The plan would keep 50 percent of the difference between the first threshold lower limit and the plan's AARCC, as well as 100 percent of the difference between the target amount and first threshold lower limit. If a plan's AARCC is less than the second threshold lower limit, the government recoups 80 percent of the difference between the plan's AARCC and the second threshold lower limit, as well as 50 percent of the difference between the first and second threshold lower limits. In this case, the plan would keep 20 percent of the difference between the plan's AARCC and the second threshold lower limit, 50 percent of the difference between the first and second threshold lower limits, and 100 percent of the difference between the target amount and the first threshold lower limit.

Example: If a plan's AARCC is $80 and its target amount is $100 of the $20 in unexpected savings generated, the Part D sponsor keeps $9.50, and the government recoups $10.50. The sponsor's share is calculated as follows:

100% of ($100 − $95) + 50% of ($95 − $90) + 20% of ($90 − $80).

Section F. 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.[59]

[59] Please see the Draft CY 2025 Part D Redesign Program Instructions published concurrently with this Advance Notice.

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.[60] 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 III-8.

Table III-8. Updated Retiree Drug Subsidy Amounts in CY 2025

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

Section G. RxHCC Risk Adjustment Model

G1. Background on RxHCC Risk Adjustment Model

The prescription drug hierarchical condition category (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. If the enrolled population is expected to be more costly or less costly than the average, risk adjustment ensures that plan payments account for the difference in risk.

Sources of Data

The RxHCC model uses beneficiary demographic characteristics and diagnosis information from a base year (i.e., data collection year) to predict expected plan spending for drug costs in the following year (i.e., the payment year) under the basic Part D drug benefit.

- Demographic information, such as beneficiary age, sex, disability status, low income, and long-term institutional status, is obtained from CMS administrative data.
- Diagnosis information is collected whether beneficiaries are enrolled in MA or FFS for their medical care. Diagnoses are collected from FFS claims and MA encounter data and are grouped into RxHCCs based on severity and cost.
- Gross prescription drug expenditures are collected from Prescription Drug Event (PDE) data.

[60] 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.

Mapping of PDE costs onto future payment year benefit structure

PDEs used to develop the model are always from years prior to the payment year. Individual PDEs reflect costs paid by plans, beneficiaries, and the government for the benefit structure in place for that year. However, because the RxHCC model is used to predict plan spending in a future year when the benefit will be different, each PDE in the model sample needs to have payments reallocated to the standard benefit structure for that year. The spending totals used to calibrate the model reflect how much a plan would have spent for a drug if the future payment year's basic benefit structure was in place when the PDE occurred. The model includes costs for which the plan is financially liable; in other words, the model excludes costs paid for entirely by the government (reinsurance and the low-income subsidy) or the beneficiary. It also excludes enhanced benefits provided above and beyond the defined standard benefit structure.

For each PDE in the year used for calibrating model expenditures, gross drug costs are reallocated among the plan, the beneficiary, the government, and manufacturer discounts according to the benefit design in the future payment year (in this case, CY 2025). For modeling, "benefit design" does not refer to future benefit parameters (e.g., deductible and out-of-pocket threshold dollar values), but instead to the cost-sharing proportions for each entity (beneficiary, government, manufacturer, plan) in each phase of the standard Part D benefit. Section A2 explains how costs were reallocated for the CY 2025 benefit structure, because the IRA redesigned the benefit such that these cost-sharing allocations are different from prior years.

Example of PDE re-mapping

Below we present a hypothetical example of how reallocating costs to the CY 2025 benefit structure would work for a PDE that had a gross drug cost of $10,000. For the example below, we will also make the following assumptions:

- Current TrOOP spending on other prescriptions: $200
- PDE description: Applicable drug with gross drug costs of $10,000
- Benefit parameters (under post-IRA benefit structure)
    - Deductible: $450
    - OOP threshold: $2,000

<u>Phase 1: Deductible phase</u>

Up to the deductible, the beneficiary covers all costs, so there are no costs allocated to the plan:

- Beneficiary pays $250 to meet deductible
    - Total TrOOP: $450
- Plan pays $0

    - Total plan liability: $0
- Remaining gross drug costs: $9,750

Phase 2: Initial coverage phase

In the initial coverage phase, the beneficiary is responsible for 25 percent of the remaining gross drug costs, which is $9,750 * 0.25= $2,437.50. However, the annual OOP threshold is $2,000, at which point the beneficiary would not be responsible for any further cost-sharing.

The beneficiary needs to spend another $1,550 ($2,000-$450=$1,550) in TrOOP to meet the $2,000 annual OOP threshold. Plan liability is calculated by dividing $1,550 by 0.25 to get the gross drug cost for this phase of the benefit ($6,200) that results in the beneficiary's 25 percent cost share being $1,550. This gross drug cost is allocated according to the rules of the initial coverage phase: 25 percent to the beneficiary ($1,550), 65 percent to the plan ($4,030), and 10 percent to the manufacturer discount ($620).

- Beneficiary pays $1,550 to meet the annual OOP threshold
    - Total TrOOP: $2,000
- Plan pays $4,030
    - Total plan liability: $4,030
- Manufacturer pays $620
- Remaining gross drug costs: $3,550

Phase 3: Catastrophic phase

In the catastrophic phase, beneficiaries pay no cost-sharing. The remaining $3,550 in gross drug costs are allocated according to the rules of catastrophic coverage: 60 percent goes to the plan ($2,130), 20 percent to the manufacturer discount ($710), and 20 percent to Medicare reinsurance ($710).

- Plan pays $2,130
    - Total plan liability: $6,160
- Manufacturer pays $710
- Medicare reinsurance $710
- Remaining gross drug costs: $0

Relative Factors and Risk Scores

Before the model is used to predict expected drug costs in the future payment year (in this case, PY 2025), it is first calibrated on historical data to determine the association between diagnosis and demographic information and expected plan spending for drug costs. Using the demographic and diagnosis information from one calibration year, the model predicts expected plan spending

for drug costs in the following calibration year. For example, the current RxHCC model for non-PACE organizations is calibrated using 2018 diagnosis information to predict 2019 expenditures.

The predicted plan spending values for each model factor (i.e., diagnosis and demographic characteristics) are then divided by the average predicted per capita expenditure – referred to as the denominator – for a given year to generate relative factors for each of the model factors. The relative factors represent the marginal, or additional, expected plan spending for drug costs for each model factor, holding all else the same. Relative factors are used to calculate risk scores for each beneficiary to use in calculating payments. See Section G6 for more details on how relative factors and risk scores are calculated.

Model Segments

As mentioned before, the model comprises separate relative factors for subsets of beneficiaries that have distinct cost and utilization patterns. This allows the RxHCC model to produce separate risk scores for different subsets of Part D beneficiaries based on community versus institutional status, low-income status, and aged versus disabled status.

There are eight unique beneficiary subsets ("model segments"):

- Five segments are for continuing enrollees, who are defined as beneficiaries who had 12 months of enrollment in Part B in the base year (when diagnosis information is collected). (12 months of Part B is used as a way to identify beneficiaries who have an adequate amount of diagnoses to calculate a risk score.)
    - Community, Non-Low Income, Age 65+
    - Community, Non-Low Income, Age<65
    - Community, Low Income, Age 65+
    - Community, Low Income, Age < 65
    - Institutional[61]
- Three segments are for new enrollees, who are beneficiaries with fewer than 12 months of enrollment in Part B in the base year.
    - Non-Low Income
    - Low-Income
    - Institutional

Relative factors for each model segment are presented in Attachment VI.

[61] To determine a beneficiary's institutional status for payment purposes, CMS uses the reporting of a 90-day assessment in the Minimum Data Set (MDS) from nursing homes.

G2. Recalibrated RxHCC Model to Reflect CY 2025 Part D Benefit Structure

The IRA has made substantial changes to the Part D benefit for 2025 and gross plan liability is expected to increase as a result. CMS recalibrated the RxHCC model to account for these changes and improve the model's accuracy under the 2025 Part D benefit. Stakeholders have submitted unsolicited comments to CMS, as well as responses to a user group call on this model update held in September 2023, that they strongly believe that an updated Part D risk adjustment model is necessary for plan sponsors to develop accurate bids for 2025. In addition, some ESRD oral drugs will be covered by Part B in 2025 and were removed from the model. As mentioned above, to calibrate the model CMS re-maps gross drug costs from prior years according to the benefit design in the future payment year (CY 2025). CMS has had to make updates to the algorithm used to map drug costs to reflect the new benefit design phases and cost-sharing proportions established by the IRA, and other benefit changes. Table III-9 summarizes these changes.

Table III-9. Summary of IRA Changes

Benefit Design Element	Pre-IRA Structure	Post-IRA Structure	Changes to RxHCC Model Mapping Algorithm
Benefit phases	Four-phase benefit: • Deductible phase • Initial coverage phase • Coverage gap phase • Catastrophic phase	Three-phase benefit: • Deductible phase • Initial coverage phase • Catastrophic phase	Updated to reflect three-phase benefit structure.
Beneficiary cost-sharing for insulin and adult vaccines recommended by Advisory Committee on Immunization Practices (ACIP)	Normal plan and beneficiary cost-sharing for given benefit phases	Deductible will not apply to covered insulin products and, in initial coverage phase, beneficiary cost-sharing capped at $35 for a one-month supply. Deductible will not apply to ACIP-recommended adult vaccines, and vaccines are exempt from all beneficiary cost-sharing and fees in all benefit phases.	Updated to reflect new beneficiary cost-sharing, with differences between new beneficiary cost-sharing and gross drug costs allocated to plans.

Benefit Design Element	Pre-IRA Structure	Post-IRA Structure	Changes to RxHCC Model Mapping Algorithm

Cost-sharing in catastrophic phase of benefit	• 80% Medicare reinsurance
	• 15% plans
	• 5% (or fixed copayment) beneficiaries
		• Zero cost-sharing for beneficiaries
		• For applicable drugs:
		  ○ 60% plans
		  ○ 20% Medicare reinsurance
		  ○ 20% manufacturer discount (phased-in for subset of manufacturers) [62]
		• For non-applicable drugs
		  ○ 60% plans
		  ○ 40% Medicare reinsurance
			Changed to reflect new cost-sharing proportions. See section below on "Additional Details on IRA Updates" for more information on how phased-in manufacturer discounts were estimated for CY 2025.

Annual OOP threshold	$8,000 (in CY 2024) • Manufacturer discounts count toward TrOOP. • Supplemental benefits do not count toward TrOOP. • Adjusted each year by APIs.	$2,000 (CY 2025) • Manufacturer discounts do not count toward TrOOP. • Supplemental benefits count toward TrOOP.	Changed to reflect change in manufacturer discounts counting toward true out-of-pocket costs, as well as changes to supplemental benefits provided by Part D sponsors and group health plans that now will count toward TrOOP. See section below on "Additional Details on IRA Updates" for more information on how lowered out-of-pocket threshold was modeled for prior data years used to calibrate model.

[62] The IRA provides for lower applicable discounts for certain manufacturers' applicable drugs marketed as of August 16, 2022 during a multi-year phase-in period, which concludes by 2031. There are two such phase-ins: one for certain applicable drugs of specified manufacturers when dispensed to applicable beneficiaries who are eligible for LIS and one for certain applicable drugs of specified small manufacturers when dispensed to applicable beneficiaries. For drugs that are subject to a phased-in discount, plans are responsible for covering the difference between the phased-in discount and the full discount that otherwise would have applied (10 percent in initial coverage phase and 20 percent in the catastrophic phase).

Benefit Design Element	Pre-IRA Structure	Post-IRA Structure	Changes to RxHCC Model Mapping Algorithm
Manufacturer discounts for applicable drugs	In coverage gap phase (for non-LIS beneficiaries): 70% discount	• In initial coverage phase: 10% discount (phased-in for subset of manufacturers) • In catastrophic phase: 20% discount (phased-in for subset of manufacturers)	Changed to reflect new discount proportions. See section below on "Additional Details on IRA Updates" for more information on how phased-in manufacturer discounts were estimated for CY 2025.
Coverage of oral-only ESRD drugs (non-IRA change)	Covered under Part D	Covered under Part B (starting in CY 2025).	Updated to reflect this change.

Additional Details on IRA Updates

As mentioned in the table above, two IRA-related changes required additional steps to be incorporated into the mapping algorithm used to assign gross plan liability for model calibration.

Lowering of the annual OOP threshold to $2,000. This threshold is lower than the annual OOP threshold in previous years, so if adjustments were not made to the annual OOP thresholds reflected on the PDEs from prior years, the re-mapping algorithm would allocate a higher proportion of costs to the initial coverage phase than would be appropriate for CY 2025.

For the CY 2025 model, we estimated what the annual OOP threshold would have been in prior data years if the post-IRA benefit structure had been in place for those years. To do this, we used annual percentage increases from Rate Announcements going back to CY 2019 to deflate the $2,000 annual OOP threshold in CY 2025 to a lower value in prior years. This is the same approach that is used annually to increase the benefit parameters for Part D to account for inflation in drug costs, but we are assuming that the CY 2025 value of $2,000 would be the result of using posted APIs every year since CY 2019.

To deflate the threshold, we divided the annual OOP threshold in CY 2025 by an early estimate of the API for 2025.[63] Then, for each year going back to CY 2019, we divided the resulting

[63] The CMS Office of the Actuary (OACT) provided an early estimate of the API for CY 2025 to use for this analysis because the published API was not available at the time of the model calibration.

adjusted annual OOP threshold by the posted API from the Rate Announcement for each year, resulting in the following adjusted OOP values. As with the calculation of annual OOP threshold parameter increases each year, these adjusted OOP values were rounded to the nearest $50.

Table III-10. Published API and Adjusted OOP

Data Year	Published API	Adjusted OOP
2025	0.9931[64]	$2,000
2024	1.0801	$2,000
2023	1.0508	$1,850
2022	1.0731	$1,750
2021	1.0285	$1,650
2020	1.0521	$1,600
2019	1.0194	$1,550

Because the deductible is not expected to decrease similarly to the annual OOP threshold in CY 2025, and will continue to increase year-over-year in the same manner as in previous years, we did not perform this step to adjust the deductible for prior years. The deductible in prior years is an appropriate amount given the post-IRA benefit structure and, further, has an appropriate relative value to the "IRA like" annual OOP threshold for these earlier years. That is the ratio of the deductible to the annual OOP threshold in the data year used to calibrate the model is comparable the ratio in 2025.

Phased-in manufacturer discounts. As previously mentioned, the IRA provides for lower applicable discounts for certain manufacturers' applicable drugs marketed as of August 16, 2022, during a multi-year phase-in period, which concludes by 2031.

For CY 2025, in order to take account of the phased-in discounts in the 2025 RxHCC model, CMS will rely on ownership information provided in HPMS by manufacturers that submit the required information in HPMS and enter into a Discount Program agreement by the statutory deadline of March 1, 2024. Because this ownership information collection process will not be complete until that time, it was not available to use for determining a complete list of which drugs would be applicable for phased-in discounts for the CY 2025 RxHCC model.

Manufacturers were identified for phased-in discounts in the model consistent with the statutory requirements for being assigned as specified manufacturers and specified small manufacturers.

[64] The CMS Office of the Actuary provided an early estimate of 2025 API that was applied for model calibration.

After determining a list of manufacturers that potentially could meet the criteria for either specified manufacturers or specified small manufacturers, we identified all NDC-9 codes associated with these manufacturers in the data year and then updated the mapping of the PDEs used in the model calibration to reflect the phase in for the drugs with these codes to reflect the additional plan liability to account for a phased-in discount. For specified manufacturers, the plan liability proportion of cost-sharing for applicable drugs dispensed to low-income beneficiaries was increased to 74 percent during the initial coverage phase and 79 percent during the catastrophic phase. No changes were made to drugs dispensed to non-LIS beneficiaries, because these drugs are not eligible for the phased-in specified manufacturer discount. For specified small manufacturers, the plan liability proportion of cost-sharing for applicable drugs dispensed to all beneficiaries was increased to 74 percent during the initial coverage phase and 79 percent during the catastrophic phase.

For calibrations of the RxHCC model for years after CY 2025, we will use the finalized lists based on ownership information reported by manufacturers as part of the Discount Program in the model calibration.

G3. Updates to Data Years Used to Calibrate the Model

Medicare Advantage Prescription Drug Plans (MA-PDs) and Standalone Prescription Drug Plans (PDPs)

For non-PACE organizations, including MA-PDs and PDPs, the RxHCC model used in CY 2023 and CY 2024 was calibrated on 2018 diagnoses and 2019 expenditure data from the PDE records. In the CY 2024 Advance Notice, we expressed concerns about using data affected by the COVID-19 pandemic because utilization had decreased, which resulted in depressed risk scores.[65] Further, if the model is calibrated on data with fewer diagnoses than typical, but costs that are closer to typical, model coefficients may not be predicted similarly to coefficients in later years. In the RxHCC model, spending associated with unreported diagnoses is instead reflected in demographic coefficients or in correlated RxHCC coefficients (such as for comorbidities), so the average cost per beneficiary would still be accurately predicted. However, we believe that there are advantages in using more recent prescription drug expenditures to predict plan liability. First, we have regularly received comments to use more recent data in the RxHCC risk adjustment model because prescription drug expenditures change more quickly than medical costs. Furthermore, more recent data is prudent in the context of the benefit design update, since the more recent cost and utilization patterns reflected in the more recent data is likely to be closer to the patterns expected in 2025.

[65] CY2024 Advance Notice, Attachment II, Section K.

We have also examined analyses of historical drug spending that suggests that drug spending was less affected by the COVID-19 pandemic than medical spending. The CMS Office of the Actuary found that Part A and Part B benefit spending growth was significantly reduced in 2020 and continued throughout the public health emergency, but these patterns were more moderate for prescription drug spending.[66] Additionally, the HHS Office of the Assistant Secretary for Planning and Evaluation found that many of the trends in drug spending prior to the pandemic continued into the pandemic, suggesting that the spending on prescription drugs was not impacted as significantly by the pandemic as other health care services.[67] Finally, we conducted similar analyses of Part D plan gross drug spending between 2017 and 2022. We found that while year-over-year growth in average per beneficiary plan spending was lower from 2019 to 2020, the first year of the pandemic, this growth rate increased in 2021 and 2022. This pattern is similar for both low-income and non-low income populations, but the increase in the growth rate for low-income beneficiaries in 2021 and 2022 tends to be higher than non-low income beneficiaries. In the long-term institutional population, average per enrollee plan spending decreased in 2020, which we attribute to pandemic-related deaths in this population, and while the growth in spending has increased since 2020, spending levels are still similar to 2019 levels.

Therefore, we believe that more recent data outweigh concerns about the potential impact of the pandemic on the model coefficients.

As a result, for non-PACE organizations, we are proposing to calibrate the RxHCC model for CY 2025 on 2021 diagnoses and 2022 expenditure data from PDE records, the most recent complete data available.

We also present a model updated to reflect the same changes in benefit and plan liability, but calibrated on 2018 diagnoses and 2019 expenditures, the most recent two years not affected by the COVID-19 pandemic. We welcome comment from stakeholders on the value and benefit of using the different model calibration years, and the effects of COVID-19 on 2021 diagnoses and 2022 expenditures.

PACE Organizations

For PACE organizations, the RxHCC model used in CY 2023 and CY 2024 was an older clinical version calibrated on 2014 diagnoses and 2015 expenditure data from the PDE records. For CY2025, we are proposing to update the clinical version of the RxHCC risk adjustment model used to pay PACE organizations to the most recent clinical version, aligning the clinical version

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[66] See Table V.D1 of 2023 Annual Report of the Boards of Trustees of the Federal Hospital Insurance and Federal Supplementary Insurance Trust Funds (March 31, 2023). Available from https://www.cms.gov/oact/tr/2023.

[67] Parasrampuria, S. and Murphy, S. Trends in Prescription Drug Spending, 2016-2021. Washington, DC: Office of the Assistant Secretary for Planning and Evaluation, U.S. Department of Health and Human Services. September 2022

used for PACE with non-PACE, and calibrate the model to account for the same benefit changes discussed above using 2018 diagnoses and 2019 expenditures.

Because RAPS data is still the primary source of diagnoses for PACE organizations, the PACE RxHCC risk adjustment model has to be calibrated using the specialty-based filtering logic that aligns with the logic PACE organizations use to submit risk adjustment eligible diagnoses to RAPS. If the model is not calibrated using the specialty code filtering logic, payments to PACE organizations would be inaccurate.

We are proposing to update the data years for model calibration for PACE organizations to the most recent available data that both 1) still has MA-PDs submitting RAPS data[68] and 2) avoids using data that is most affected by the COVID-19 pandemic.

G4. Clinical Updates to Prescription Drug Hierarchical Condition Categories for PACE organizations

For PACE organizations, in order to better align the structure of the RxHCC model with non-PACE organizations, we are proposing a clinical update to the RxHCCs that matches the RxHCC classifications used in the non-PACE model. This clinical revision means that all Part D plans will use RxHCCs based on ICD-10-CM diagnosis codes rather than ICD-9 codes used in the prior models. These changes were explained in more detail in the CY2023 Advance Notice.[69]

G5. Changes in Age Category Model Constraints

The IRA changes in the Part D standard benefit design generally result in increased plan liability for beneficiaries with high-cost RxHCCs. This occurs because these beneficiaries are expected to spend more time in catastrophic coverage due to the lowering of the annual OOP threshold, in conjunction with the increase in plan liability for costs in the catastrophic phase. The updated RxHCC models tend to have lower coefficients for age categories, as expected plan liability is more strongly associated with RxHCCs than age categories under the new Part D standard benefit design. A higher number of age category coefficients were negative under the new benefit design, which in prior years would involve constraining these coefficients to zero to prevent a negative risk score. However, because more age categories would have coefficients of zero under the new model, this posed a risk of having more beneficiaries with risk scores of zero if they did not have any of the RxHCCs included in the model.

For CY 2025, we are proposing a new constraint for age categories for both PACE and non-PACE versions of the RxHCC model. Negative coefficients for age categories will be

[68] For payment in CY 2022 (2021 dates of service), we did not use RAPS data to calculate risk scores for non-PACE organizations. See CY2022 Advance Notice, Part II, Attachment II, Section N. for more details.

[69] CY2023 Advance Notice, Attachment III, Section A.

constrained to be equal to other age categories that have positive coefficients, such that the resulting coefficient represents an enrollment-weighted average of the negative and positive coefficients. This ensures that all age categories have positive coefficients, preventing beneficiaries from receiving a risk score of zero.

G6. Model Calibration Steps

The RxHCC model sample comprises all beneficiaries who were in FFS or Medicare Advantage (MA-PD or MA-only) for all 12 months of the base year (2021 for non-PACE organization and 2018 for PACE organizations) and were enrolled in a PDP or an MA-PD for at least one month in the prediction year (2022 for non-PACE organizations and 2019 for PACE organizations). The sample does not include EGWPs, PACE organizations, or Medicare cost plans. Because these plan types use a different benefit structure (e.g., cost-sharing arrangements) than the Part D standard benefit, their expenditures would not accurately reflect typical Part D plan expenditures.

Coefficients for condition categories were estimated by regressing the plan liability for the Part D defined standard benefit for each beneficiary onto their demographic factors and condition categories, as indicated by their diagnoses. Resulting dollar coefficients represent the marginal (additional) cost of the condition or demographic factor (for example, age and sex groups). As discussed above, beneficiaries are segmented based on low-income status, disability status, and residence setting (community vs. institutional), and whether they are new enrollees (have less than 12 months of Part B in the data collection period). Age groups are defined for beneficiaries based on their age on February 1 of the prediction year (2022 for non-PACE organizations and 2019 for PACE organizations). Beneficiaries who age into Medicare after February 1 of the prediction year are treated as 65 years old in model calibration. LIS and institutional status are determined on a month-by-month basis. Plan liability figures for each beneficiary are annualized and weighted based on the proportion of months beneficiaries are eligible for each model segment in the prediction year.

In order to calculate risk scores for payment, the dollar coefficients are divided by the average predicted plan liability across all model segments (the denominator) to create relative factors. Denominators for the recalibrated RxHCC risk adjustment models are calculated using data from Medicare beneficiaries enrolled in both MA-PD plans and PDPs, which results in an average risk score of 1.0 for the enrolled Part D population in the denominator year. The denominator for the proposed model for non-PACE organizations (2021/2022 model) is 2022, while the denominator for non-PACE organizations (2018/2019 model) is 2020. We also provide a version of the non-PACE model calibrated on 2018 diagnoses and 2019 expenditures for comment. This model has a 2020 denominator.

When the RxHCC model is recalibrated to reflect an updated benefit structure, it can result in changes in condition category coefficients. Changes in the relative (denominated) factors can

occur when the marginal cost attributable to an RxHCC changes differently than the average beneficiary cost. Recalibration of the RxHCC model can result in changes in risk scores for individual beneficiaries and for plan average risk scores, depending on each individual beneficiary's combination of diagnoses.

In Attachment VI of this Advance Notice, we provide relative factors for the models proposed and discussed.

G7. Predictive Ratios for CY 2025 RxHCC Models

The predictive accuracy of the RxHCC model is measured by how well it predicts costs over subgroups of beneficiaries. Because the goal of the risk adjustment model is not to predict the costs of individual beneficiaries, but to predict well over subgroups of beneficiaries, we rely on subgroup-level measures of predictive accuracy. Specifically, predictive accuracy in the RxHCC models is measured by the predictive ratio – the ratio of predicted cost to actual cost – for a group of beneficiaries. A predictive ratio of 1.0 means that the model perfectly predicts plan spending on average for a subgroup of beneficiaries When evaluating the predictive power of the model, a predictive ratio between 0.90 and 1.10 is generally considered accurate.[70]

Attachment VI of this Advance Notice presents predictive ratios for the 2021/2022 model calibration proposed for non-PACE organizations, as well as the 2018/2019 reference model calibration, by the decile of predicted risk for each model segment. These predictive ratios reflect the ratio of plan spending predicted by the model for PY 2022 to the actual Part D plan expenditures for that year. Actual expenditure amounts are calculated using the remapped PDEs that reflect the CY 2025 Part D benefit structure, and that are described in section G2 above. Under both the proposed 2021/2022 calibration and the 2018/2019 reference model calibration, we find that the model tends to underpredict spending for the lowest decile of predicted risk, overpredicts for the second through fourth deciles, and generally remains around 1.0 for higher deciles. Because higher deciles reflect the highest risk in terms of expected spending, we believe that the prevalence of predictive ratios between 0.90 and 1.10 for these deciles reflect a model that predicts cost well for beneficiaries with higher predicted costs. Predictive ratios for the PACE model (2018/2019) calibration are not presented in this Advance Notice because they are nearly identical to the predictive ratios for the 2018/2019 non-PACE model calibration, as both models are based on the same years of data and only differ in the method of filtering diagnoses (HCPCS filtering for the non-PACE calibration and specialty-filtering for the PACE calibration).

[70] https://www.cms.gov/files/document/report-congress-risk-adjustment-medicare-advantage-december-2021.pdf, p. 42.

Section H. Normalization Factors for the RxHCC Models

The RxHCC risk adjustment models, as described in Section G of Attachment III, are calibrated with diagnostic and cost information for beneficiaries enrolled in standalone prescription drug plans (PDPs) and Medicare Advantage-Prescription Drug (MA-PD) plans. The risk adjustment models are prospective in that they use health status in a base year (i.e., data collection year) to estimate incremental costs for key beneficiary characteristics, such as age and gender and health conditions, in the following year (i.e., the payment year). To create relative factors, each model variable's incremental cost estimate, referred to as a dollar coefficient, is divided by the predicted average per capita expenditure for beneficiaries in both the Medicare FFS and MA program in a given year (i.e., the denominator year). Risk scores are the sum of relative factors assigned to each beneficiary based on their demographic characteristics and health status as determined by diagnosis coding reported to CMS for each enrollee. Diagnoses for beneficiaries enrolled in an MA-PD plan are submitted by the MA organization, whereas diagnoses for beneficiaries enrolled in standalone PDPs are reported on FFS claims. (Note that we take diagnoses from whichever source reported the diagnoses for the beneficiary in the data collection year. If a beneficiary was enrolled in both an MA-PD plan and a PDP during the year, we will use risk adjustment eligible diagnoses submitted by either or both the MA organization(s) and FFS providers.) The average Part D risk score is 1.0 in the denominator year across beneficiaries enrolled in MA-PD plans and PDPs. We then maintain an average 1.0 risk score across the entire Part D program in each year, by including risk scores from enrollees in both PDPs and MA-PD plans in our normalization factor calculation, which we have done since early in the Part D program.

When a risk adjustment model predicts expenditures in years other than the denominator year, the average risk score may no longer be 1.0 due to an underlying trend that reflects changes, such as those in coding and population characteristics, between the denominator year and other years. CMS applies a normalization factor to risk scores in the payment year to account for this trend in the average risk score between the denominator year (1.0) and the payment year. The normalization factor is a projection of this trend based on historical risk scores and because we apply the factor by dividing each individual risk score in the payment year by the normalization factor, it effectively keeps the average risk score at 1.0 across PDPs and MA-PD plans in the payment year.[71]

CMS has historically used one normalization factor across both PDPs and MA-PD plans. Given the much greater importance of risk adjustment in Part D due to the significant change in the

[71] See section 1853(a)(1)(C)(ii)(I) of the Act, which requires that the risk adjustment used in MA payment reflects changes in treatment and coding practices in the fee-for-service sector. Section 1860D-15(c)(1)(B) permits the Secretary to adopt similar methodologies used under section 1853(a)(3) to adjust payments to MA organizations for benefits under the original Medicare fee-for-service program option.

costs for which Part D plans will be at risk ("plan liability") under the IRA redesign of the Part D benefit in 2025, and a trend of growing divergence in risk scores between PDPs and MA-PD plans, we are proposing for 2025 to change this approach. Specifically, we are proposing to apply separate normalization factors for MA-PD plans vs PDPs.

Background: Until 2016, the relative factors in the RxHCC model were based only on FFS cost and diagnostic data from PDPs. In 2016, CMS added MA-PD plan data and implemented an RxHCC model that was calibrated with cost and diagnostic data for beneficiaries enrolled in MA-PD plans and PDPs. Specifically, the relative factors for each demographic and disease variable in the RxHCC models were established by using the following: 1) PDP diagnoses from FFS claims and MA-PD plan diagnoses from the Risk Adjustment Processing System (RAPS) data (for CY 2016 to CY 2021 payment) or encounter data (for payment starting in CY 2022), and 2) gross plan liability from Prescription Drug Event (PDE) data from both PDPs and MA-PD plans. At the time we first implemented an RxHCC model that incorporated data from both PDPs and MA-PD plans, we noted that "MA-PDs accounted for almost 40 percent of Part D enrollment and have different cost, coding, and utilization patterns than PDPs. Incorporating both FFS and MA-PD data into the Part D model allows MA-PD plan coding and utilization patterns to be accurately reflected in the Part D relative costs and improves the predictive accuracy of the RxHCC model."[72]

As MA enrollment has increased, Part D enrollment has increasingly shifted from PDPs to MA-PD plans. In 2023, about 56 percent of Part D enrollment is in an MA-PD plan. To analyze the potential impact of this population shift on Part D risk scores, we calculated the risk score trend separately for MA-PD plans and PDPs using the proposed 2025 RxHCC model. (See section G for more information on the updates made to the RxHCC risk adjustment model for 2025.) 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. Between 2016 and 2022, the average MA-PD plan risk score calculated with the proposed 2025 RxHCC model increased 17.2 percent while the average PDP risk score calculated with the same model decreased 6.6 percent. In 2022, using the proposed RxHCC model, the average MA-PD plan risk score was 18.5 percent higher than the average PDP risk score.

Given these shifts over the past 8 years since the inclusion of MA-PD plan data in 2016, and 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, we assessed how well the RxHCC model will likely predict costs for PDPs and MA-PD plans. Across all model segments in the entire market for the 2021/2022 model calibration, both the average predicted expenditures and the average actual expenditures were

[72] https://www.cms.gov/medicare/health-plans/medicareadvtgspecratestats/downloads/advance2016.pdf, p. 29.

$2,809.18, a predictive ratio of 1.000. However, this ratio differed for MA-PD plans and PDPs. For MA-PD plans, the average predicted expenditures were $2,966.05, while the average actual expenditures were $2,681.58, resulting in a predictive ratio of 1.106. For PDPs, the average predicted expenditures were $2,610.79, while the average actual expenditures were $2,969.69, resulting in a predictive ratio of 0.879. (See section G7 above for more information on predictive ratios.) As a result, we find that MA-PD plan costs tend to be overpredicted, while PDP costs tend to be underpredicted.

This differential puts upward pressure on standardized bids for PDPs and, as a result, creates an unlevel playing field that generally inhibits fair competition between MA-PD plans and PDPs. We do not think this disconnect between predicted and actual risk is sustainable given the increase in plan liability under the redesigned Part D benefit.

Though including MA-PD plan diagnoses and costs in the RxHCC model improved the accuracy of the model for the Part D program as a whole (i.e., predictions for MA-PD plans were no longer based on PDP diagnoses and costs), MA-PD plans and PDPs were differentially affected by the inclusion of the new data, as evidenced by the diverging average MA-PD and PDP risk scores over time. In order to "take into account variation in costs for basic prescription drug coverage among prescription drug plans and MA-PD plans based on the differences in actuarial risk of different enrollees being served" as directed by the Act (section 1860D-15(c)(1)(A)), we propose to calculate separate normalization factors for risk scores used to pay MA-PD plans and PDPs using the existing five-year linear slope methodology, described in more detail below. 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 has largely used the same linear slope methodology for calculating normalization factors in Part D, which is to calculate a slope using five years of risk scores – each year being an average of the risk scores of beneficiaries enrolled in MA-PD plans and PDPs – calculated using the RxHCC model for the payment year, then projecting the slope by the number of years between the denominator year to the payment year. To calculate the normalization factor using this method, we first calculate the slope from the five-year trend of historical risk scores after which we apply the equation (1+X)^n – where X is the slope, and the exponent, n, is the number of years between the denominator year and the payment year.

Like the Part C CMS-HCC model normalization factors, the proposed RxHCC model normalization factors are calculated using the five most recent average risk scores available. Distinct from the CMS-HCC risk adjustment models, which only use FFS risk scores to calculate

the normalization factors, as we discussed above, the normalization factors for the RxHCC risk adjustment models include both MA and FFS risk scores. For this reason, 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 RxHCC risk score is for 2022 (using diagnoses from 2021 dates of service), since 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 linear regression approach proposed for the CMS-HCC models, we do not believe it is prudent at this time to alter the methodology as has been proposed for the CMS-HCC models. If we applied the multiple linear regression approach to the RxHCC model for CY 2025, the "post-COVID" portion of the trend would only reflect the change from 2021 to 2022. We believe that this is not a typical year of risk score growth as it includes the rebound of risk scores after the pandemic when utilization began to increase, and the rebound would disproportionately affect the multiple linear regression approach when this year of growth is used as the sole basis for the "post-COVID" portion of the trend. In future years, when more post-pandemic risk scores are available for RxHCC models, we will evaluate the multiple linear regression approach, but at this time, we believe that using that approach for the RxHCC models could distort the normalization factor.

Normalization factors for the RxHCC model proposed for PACE organizations, which was based on a non-PACE population and calibrated using diagnoses from RAPS and FFS, must exclude the 2022 risk score in addition to the 2021 risk score. This is because CMS fully transitioned to using diagnoses solely from encounter data for CY 2022 payment for non-PACE organizations[73] so there was no longer a requirement to submit data to the RAPS system. In calculating the average historical risk scores for MA-PD plans for the RxHCC model proposed for PACE organizations (which, like the model, are based on a non-PACE population and calculated using RAPS and FFS data), CMS found that the 2022 risk score dropped by nearly 17 percent relative to the 2021 risk score and believes that the 2022 risk score is not representative of the actual average MA-PD risk score, but rather a reflection of decreased submission of data to the RAPS system. Including the 2022 risk score for the RxHCC model proposed for PACE would grossly underestimate what the average risk score is likely to be in CY 2025.

[73] Announcement of Calendar Year (CY) 2022 Medicare Advantage (MA) Capitation Rates and Part C and Part D Payment Policies

For the same reasons we discussed for the CMS-HCC model normalization factors for CY 2024,[74] CMS is proposing to maintain the five-year linear slope methodology for estimating the RxHCC model normalization factors using risk scores as stated below:

- Non-PACE organizations: 2018 through 2022, excluding 2021, consistent with the calculation of the CMS-HCC model normalization factors when 2022 was the most recent year available
- PACE organizations: 2016 through 2020, consistent with the calculation of the RxHCC model normalizations factors for CY 2023 and CY 2024

Tables III-11 to III-13 show the historical average MA-PD and PDP risk scores for the proposed and alternative RxHCC models for non-PACE organizations, as well as the MA-PD risk scores for the proposed RxHCC model for PACE organizations. We have also included the overall Part D historical risk scores for informational purposes.

Table III-11. Average MA-PD and PDP Risk Scores for the Proposed RxHCC Model for non-PACE Organizations

Year	Proposed 2025 RxHCC Model non-PACE MA-PD	Proposed 2025 RxHCC Model non-PACE PDP	Proposed 2025 RxHCC Model non-PACE Overall
2016	0.919	0.974	0.952
2017	0.940	0.973	0.959
2018	0.980	0.969	0.974
2019	1.020	0.964	0.989
2020	1.047	0.955	0.998
2021	1.029	0.898	0.965
2022	1.078	0.910	1.000

[74] Advance Notice of Methodological Changes for Calendar Year (CY) 2024 for Medicare Advantage (MA) Capitation Rates and Part C and Part D Payment Policies

Table III-12. Average MA-PD and PDP Risk Scores for the Alternative RxHCC Model for non-PACE Organizations

Year	Alternative 2025 RxHCC Model non-PACE MA-PD	Alternative 2025 RxHCC Model non-PACE PDP	Alternative 2025 RxHCC Model non-PACE Overall
2016	0.920	0.969	0.949
2017	0.943	0.971	0.959
2018	0.983	0.969	0.975
2019	1.022	0.965	0.991
2020	1.048	0.957	1.000
2021	1.031	0.902	0.967
2022	1.086	0.915	1.007

Table III-13. Average MA-PD and PDP Risk Scores for the Proposed RxHCC Model for PACE Organizations

Year	Proposed 2025 RxHCC Model PACE MA-PD	Proposed 2025 RxHCC Model PACE PDP	Proposed 2025 RxHCC Model PACE Overall
2016	0.925	0.976	0.956
2017	0.949	0.976	0.965
2018	0.985	0.975	0.979
2019	1.019	0.970	0.992
2020	1.043	0.962	1.000
2021	1.027	0.912	0.970
2022	0.857	0.910	0.882

Proposed CY 2025 Normalization factors for non-PACE organizations

Proposed Model: Using CMS's historical five-year linear slope methodology and average risk scores from 2018-2022, excluding 2021, the normalization factor is 1.073 for MA-PD enrollees and 0.955 for PDP enrollees. The proposed RxHCC model for non-PACE organizations has a 2022 denominator and there are three years of trend between the denominator year and the payment year.

Alternative Model: Using CMS's historical five-year linear slope methodology and average risk scores from 2018-2022, excluding 2021, the normalization factor is 1.131 for MA-PD enrollees and 0.932 for PDP enrollees. The alternative RxHCC model for non-PACE organizations has a 2020 denominator and there are five years of trend between the denominator year and the payment year.

Proposed CY 2025 Normalization factors for PACE organizations

Proposed Model: Using CMS's historical five-year linear slope methodology and average risk scores from 2016-2020, the normalization factor is 1.163, which is the factor calculated for MA-PD plans. We are proposing the factor that would be used for MA-PD plans for use in calculating risk scores for PACE organizations, since they function more similarly to MA-PD plans, compared with PDPs. The proposed RxHCC model for PACE organizations has a 2020 denominator and there are five years of trend between the denominator year and the payment year.

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

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

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

Refer to Attachment II, Section L1. above for additional information about sources of diagnoses for PACE risk scores.

Attachment IV. 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 Medicare Advantage (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's 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 provide 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).

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 request a review of CTM data.

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 IV-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.[75]

Table IV-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**

[75] See CY 2024 final rule (CMS-4201-F) at https://www.federalregister.gov/documents/2023/04/12/2023-07115/medicare-program-contract-year-2024-policy-and-technical-changes-to-the-medicare-advantage-program.

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	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
		Complaints Measure				
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**

Part C or D	Measure	Measure Type	Weight	Measurement Year	Improvement Measure	Included in the 2025 CAI Values
C	Reviewing Appeals Decisions	Measures Capturing Access	4	1/1/2023 – 12/31/2023	**Yes**	**No**
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**

Part C or D	Measure	Measure Type	Weight	Measurement Year	Improvement Measure	Included in the 2025 CAI Values
D	MPF Price Accuracy	Process Measure	1	1/1/2023 – 9/30/2023	**Yes**	**No**
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 IV-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's 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 IV-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's 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 2022 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.[76] Table IV-2 lists the emergency areas affected by emergency declarations first issued in 2023, as defined in section 1135 of the Act, and the exercise of the Secretary's authority under section 1135 of the Act.

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

[76] See CY 2024 final rule (CMS-4201-F) at https://www.federalregister.gov/documents/2023/04/12/2023-07115/medicare-program-contract-year-2024-policy-and-technical-changes-to-the-medicare-advantage-program.

Table IV-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 describe a number of measure concepts and changes in the Advance Notice. 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 have also 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 Measures Under Consideration (MUC) list, which includes measures that CMS is considering adopting 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"[77] 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)[78] 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 have submitted this measure through the 2023 MUC process for review by the Measures Application Partnership, which is a multi-stakeholder partnership that 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[79] as part of the Part C and D Star Ratings pending future rulemaking.

Breast Cancer Screening (Part C). The current Breast Cancer Screening measure assesses screening for members eligible for breast cancer screening aged 50-74. NCQA is considering revising the measure to assess screening for members eligible for breast cancer screening aged 40-74 for the HEDIS Measurement Year 2024 Technical Update (to be released March 2024). This change would align the measure with updated recommendations from the U.S. Preventive Services Task Force. In May 2023, the Task Force released a draft statement that recommends biennial mammography screening for women ages 40-74 years at average risk of breast cancer. We anticipate that this final recommendation will be released in fall 2023. NCQA brought this to their Committee for Performance Measurement (CPM) at their September 2023 meeting, which voted to send the change to an ad-hoc public comment in October 2023. A final staff recommendation will be brought to the CPM for review and approval in January 2024. If NCQA

[77] 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. Available at: https://www.nejm.org/doi/full/10.1056/NEJMp2215539

[78] 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.

[79] 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.

makes this update, they plan 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.

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 plans to review the measure codes with their Diabetes Measurement Advisory Panel and potentially 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.

Statin Therapy for Patients with Cardiovascular Disease (Part C). Over the past several years, NCQA has received questions related to the exclusion of members with statin intolerance from this measure. In the absence of statin intolerance diagnosis codes, 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 rechallenged statins and were deemed intolerant in the past and members who no longer have a muscle condition that would qualify them for current exclusion from the measure. 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 both measures for measurement year 2026 for continued relevance.

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 dismissed appeals 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)[80] 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

[80] https://www.medicareappeal.com/sites/default/files/Documents/New-Manual-November-2022_FINAL002.pdf

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 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 are only in effect for 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 § 422.184(d)(2) because the IRE's processes for determining timeliness and the received date would change. In accordance with § 422.184(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. We welcome feedback on these potential measure updates.

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. CMS 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. CMS 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 IV-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 IV-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.

We welcome feedback on the potential revisions to 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's 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[81] 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 is included in the 2023 measures under consideration (MUC) list for the Pre-Rulemaking Measure Review (PRMR) process[82] to inform the selection of quality and efficiency measures for CMS programs. CMS intends to propose to add the IOP-LD measure to the Part C and D Star Ratings in future rulemaking.

Medication Adherence for Diabetes Medications/Medication Adherence for Hypertension (RAS Antagonists)/Medication Adherence for Cholesterol (Statins)/ Statin Use in Persons

[81] https://www.cms.gov/medicare/prescription-drug-coverage/prescriptiondrugcovgenin

[82] https://p4qm.org/PRMR

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 enrolled 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 are proposing to change the data sources used to identify beneficiaries with a hospice stay and/or ESRD status (ESRD dialysis coverage dates) from the Enrollment Database (EDB) to the Common Medicare Environment (CME). The EDB is part of the CME database, and accessing enrollment information through the CME will improve data availability for the monthly Patient Safety reports for the Medication Adherence and SUPD measures. The CME data will be retrieved from the Integrated Data Repository (IDR).

Currently, in these Part D Star Ratings, we use the EDB to identify hospice enrollment and ESRD status (using ESRD dialysis dates that overlap with the measurement year) as applicable to the measure specifications. However, we are proposing to remove the EDB as a data source to identify hospice enrollment and ESRD status and instead use the CME to identify hospice enrollment and ESRD status beginning with the 2024 measurement year. The CME database 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.[83,84] CMS does 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.

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. Currently, 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

[83] CCW White Paper Master Beneficiary Summary File (MBSF): Impact of Enrollment Source Data Conversion From EDB to CME at https://www.ccwdata.org/documents/10280/19002256/medicare-enrollment-impact-of-conversion-from-edb-to-cme.pdf.

[84] SORN 09-70-0502 at https://www.hhs.gov/foia/privacy/sorns/09700502/index.html.

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 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 starting with the 2026 Star Ratings.

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). Both of these updates would 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, starting at the earliest with the 2025 measurement year 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. Additionally, the current measure is only reported for Special Needs Plans; however, a wider population of MA members could benefit from a pain assessment and follow-up measure. Thus, NCQA is working towards developing a new measure 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"[85] 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 this Advance Notice, CMS is announcing 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.

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 validity, as well as its alignment with the larger suite of HEDIS behavioral health care coordination measures. NCQA is considering expanding the measure's population and options for follow-up. To address the expansion of the measure's population, NCQA is considering relaxing the denominator criteria to include acute psychiatric events that are coded with a mental health-related condition as a secondary diagnosis. NCQA is reviewing additional mental health-related diagnosis codes for inclusion in the denominator (i.e., anxiety disorders, phobia-related disorders, and the ICD-10 X chapter of intentional self-harm codes). NCQA is also planning to examine if follow-up by any care provider for a mental health-specific service is appropriate after discharge from the acute inpatient setting. NCQA is exploring relaxing the diagnosis position criteria on the follow-up

[85] https://www.federalregister.gov/documents/2023/04/12/2023-07115/medicare-program-contract-year-2024-policy-and-technical-changes-to-the-medicare-advantage-program.

claim to include encounters with a diagnosis of mental health in any position on the claim, rather than the principal only. Lastly, NCQA plans to assess the inclusion of services provided by other types of providers in the numerator for "follow-up" (e.g., occupational therapy and peer support services). NCQA plans to test these potential updates and obtain input from their advisory panels. We welcome feedback on these potential updates.

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. We are adding this measure to the display page for the 2025 Star Ratings. NCQA is exploring 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 (1 month) of screening positive for an unmet utility need. In alignment with the current measure interventions, these would be captured using the nine categories defined by the Gravity Project: adjustment, assistance, coordination, counseling, education, evaluation of eligibility, evaluation/assessment, provision, and referral. This utility insecurity addition to NCQA's measure aligns with CMS's Addressing Social Needs measure[86] under development, which currently includes a utilities indicator. The addition also aligns with evidence found of high utility insecurity and the association between utility insecurity and health outcomes. 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. We welcome feedback on this potential update to the Social Need Screening and Intervention measure.

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 Advisory Committee on Immunization Practices (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.

[86] https://mmshub.cms.gov/sites/default/files/Yale-CORE-ASN-measure-specs-for-public-comment.pdf.

After ACIP updated their pneumococcal vaccine recommendations in 2023[87] 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.

Polypharmacy: Use of Anticholinergic Medications in Older Adults (Poly-ACH) (Part D). The PQA updated the Poly-ACH measure specifications in the draft 2024 Measure Manual to align with the American Geriatric Society 2023 Updated Beers Criteria for Potentially Inappropriate Medication Use in Older Adults.[88] 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, 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).

Polypharmacy: Use of Multiple CNS-Active Medications in Older Adults (Poly-CNS) / Poly-ACH (Part D). Per the PQA's draft 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

[87] https://www.cdc.gov/mmwr/volumes/72/rr/rr7203a1.htm

[88] American Geriatrics Society 2023 updated AGS Beers Criteria® for potentially inappropriate medication use in older Adults at https://agsjournals.onlinelibrary.wiley.com/doi/10.1111/jgs.18372.

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.

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.[89] We will also consider applying the updated measure specifications if implemented by the PQA.

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,[90] 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.

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

[89] CDC Clinical Practice Guideline for Prescribing Opioids for Pain – United States, 2022 at https://www.cdc.gov/mmwr/volumes/71/rr/rr7103a1.htm?s_cid=rr7103a1_w.

[90] https://www.cms.gov/files/document/2024-announcement-pdf.pdf

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. The PQA Quality Metrics Expert Panel (QMEP) will vote on the removal of the anchor date in early 2024. If the QMEP votes in support of removing the anchor date, effective measurement year 2024, then CMS will also not implement the anchor date to the applicable measures. Therefore, when CMS implements the CE methodology for these measures beginning with the 2024 measurement year, the anchor date specification will be removed.

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 Medication Adherence, SUPD, and MTM measures, we are proposing to remove the EDB as a data source to identify hospice enrollment and ESRD status (if applicable to the measure specifications) and instead use the CME to identify hospice enrollment and ESRD status beginning with the 2024 measurement year. If the change is made for the Star Rating measures, it will also be made for these display page and Patient Safety measures that also exclude individuals in hospice status or with ESRD. As noted previously above, the CME database 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. CMS does not anticipate any impact on measure calculations due to this update. Based on our analysis, the CME and EDB data sources results are very closely aligned on measure exclusions.

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.

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 Quality Metrics Expert Panel 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.

Potential New Measure Concepts and Methodological Enhancements for Future Years

CMS's 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 MUC process, and undertaking notice and comment rulemaking to propose and finalize new measures. CMS is soliciting 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 MUC 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,[91,92] 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[93] measures

[91] HealthMeasures, "Search & View Measures." Available at https://staging.healthmeasures.net/search-view-measures. Accessed on March 10, 2023.

[92] 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.

[93] 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[94] and MA enrollees with disabilities.[95] 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's 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.

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 Blood Pressure measure from HEDIS assesses the percentage of members 18-85 years of age

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[94] 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. Available at https://www.kff.org/medicare/issue-brief/one-in-four-older-adults-report-anxiety-or-depression-amid-the-covid-19-pandemic/. Accessed on March 15, 2023.

[95] Friedman, C. (2022). The mental health of Medicare beneficiaries with disabilities during the COVID-19 pandemic. *Rehabilitation Psychology*, *67*(1), 20.

with hypertension whose blood pressure was adequately controlled (<140/90 mmHg). NCQA plans to test a new approach 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 will test a lower evidence-based blood pressure control threshold (<130/80 mmHg) and leverage structured electronic clinical data for assessing the last reading in the measurement year. The new measure concept is being explored for measurement year 2025 and beyond. 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. We welcome feedback on this new measure concept.

Breast Cancer Screening Follow-Up (Part C). NCQA is exploring the development of a new measure to assess documentation and follow-up of abnormal mammogram results. This measure would expand on the current Breast Cancer Screening measure and would be developed as an Electronic Clinical Data Systems (ECDS) measure. NCQA is considering including two rates for the measure: Documented Breast Imaging Reporting and Data System (BI-RADS) Assessment following a mammogram and Follow-up After Abnormal Screening. This new measure is currently in development for measurement year 2025. We welcome feedback on this new measure concept.

Social Connection Screening and Intervention (Part C). NCQA is developing a new measure for measurement year 2025 that assesses 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. The social connection screening indicator would include HCPCS code G1036 as an additional option to capture screenings, while the intervention indicator would include an option to submit Z codes or new procedural HCPCS codes. This measure would be reported using electronic clinical data, including data from electronic health records, registries, case management systems, and administrative claims. CMS is considering proposing this measure as a Star Ratings measure in the future through rulemaking. We welcome feedback on this measure.

Chronic Pain Assessment and Follow-Up (Part C). NCQA is developing a new measure for measurement year 2025 at the earliest that would assess chronic pain and follow-up in Medicare members aged 65 and older. This measure is intended to replace the Care for Older Adults -- Pain Assessment indicator planned for retirement and would expand beyond the Special Needs Plan population. The measure would assess the percentage of members screened for pain, percentage of members who screened positive for pain who had a documented multidimensional assessment, and percentage of members with pain who had follow-up. This measure would be

reported using ECDS reporting. CMS is considering proposing this measure as a Star Ratings measure in the future through rulemaking. We welcome feedback on this measure.

Tobacco Use Screening and Cessation and Lung Cancer Screening and Follow-Up (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 and received recommended follow-up based on findings. 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. We welcome feedback on these new measures.

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. We welcome feedback on this measure concept.

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.[96] 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

[96] Refer to the Star Ratings Technical Notes at: https://www.cms.gov/medicare/prescription-drug-coverage/prescriptiondrugcovgenin/performancedata

beneficiaries to have reliable price comparisons to base their plan selections on for the upcoming year.

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 evaluate 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.

Currently, we are seeking initial comment on this general measure concept. CMS is also interested in 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[97]). 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.

[97] Refer to the 2024 Pricing Data Guidelines at: https://www.cms.gov/medicare/prescription-drug-coverage/prescriptiondrugcovcontra/rxcontracting_formularyguidance

- 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 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.[98]
- 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.

[98] Refer to the Star Ratings Technical Notes at: https://www.cms.gov/medicare/prescription-drug-coverage/prescriptiondrugcovgenin/performancedata

Attachment V. Economic Information for the CY 2025 Advance Notice

Below, we provide the economic information for significant provisions in the Advance Notice. 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. We note that the information provided below is likely to change as the rates and underlying assumptions are updated; we will provide revised impact estimates in the Rate Announcement that reflect the payment methodologies being finalized and the latest data available.

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 2.57 percent, and the MA growth percentage for the 2025 MA non-ESRD rates is estimated to be 1.98 percent. As a result, the effective growth rate for 2025 MA non-ESRD rates is estimated to be 2.44 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 $9.2 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 1.98 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 $40 million. This figure accounts for the portion of the program costs covered by Part B premiums.

If we continue the adjustment to the calculation of county benchmarks in Puerto Rico for the number of beneficiaries with zero claims, then 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 3.12 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 $730 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 proposing to calculate 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 proposed 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 proposing to calculate 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 proposing to use 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 proposing to calculate 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. This update is focused on updating the model to reflect the statutory changes in the Part D benefit structure for CY 2025. As described in Attachment III, CMS is proposing a model calibrated on 2021 diagnoses and 2022 expenditures for non-PACE organizations and a model calibrated on 2018 diagnoses and 2019 expenditures for PACE organizations. 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 proposing to calculate normalization factors 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 VI. RxHCC Risk Adjustment Factors and Predictive Ratio Tables

Table VI-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

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
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
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	-	-

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
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
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

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
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
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

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
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 VI-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 VI-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 VI-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 VI-5. 2025 RxHCC Model Relative Factors for Continuing Enrollees (2018/2019 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		-	0.194	-	0.458	2.195
35-44 Years		-	0.293	-	0.640	2.523
45-54 Years		-	0.331	-	0.653	1.917
55-59 Years		-	0.294	-	0.509	1.583
60-64 Years		-	0.229	-	0.312	1.329
65-69 Years		0.119	-	0.284	-	1.406
70-74 Years		0.111	-	0.038	-	1.083
75-79 Years		0.086	-	0.038	-	0.786
80-84 Years		0.009	-	0.038	-	0.545
85-89 Years		0.009	-	0.038	-	0.353
90-94 Years		0.009	-	0.038	-	0.187
95 Years or Over		0.009	-	0.038	-	0.019
Male						
0-34 Years		-	0.163	-	0.549	2.311
35-44 Years		-	0.203	-	0.593	2.068
45-54 Years		-	0.262	-	0.535	1.780
55-59 Years		-	0.279	-	0.440	1.373
60-64 Years		-	0.271	-	0.328	1.068
65-69 Years		0.170	-	0.293	-	1.072
70-74 Years		0.147	-	0.215	-	0.781
75-79 Years		0.064	-	0.064	-	0.637
80-84 Years		0.064	-	0.064	-	0.456
85-89 Years		0.064	-	0.064	-	0.274
90-94 Years		0.064	-	0.064	-	0.108
95 Years or Over		0.064	-	0.064	-	0.108
Originally Disabled Interactions with Sex						
Originally Disabled Female		0.042	-	0.305	-	0.224
Originally Disabled Male		-	-	0.175	-	0.224
Disease Coefficients						
RXHCC1	HIV/AIDS	7.910	9.670	8.416	8.861	5.626
RXHCC5	Opportunistic Infections	0.370	0.464	0.557	0.423	0.479
RXHCC15	Chronic Myeloid Leukemia	5.723	4.802	14.040	18.927	9.504
RXHCC16	Multiple Myeloma and Other Hematologic Cancers	13.015	14.551	11.384	12.168	4.112
RXHCC17	Secondary Cancer of Bone and Kidney	5.680	4.802	9.156	8.273	4.112

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
RXHCC18	Secondary Cancer of Lung, Liver, Brain, and Other Sites	2.169	1.982	3.117	3.021	1.027
RXHCC19	Leukemias and Other Hematologic Cancers	2.169	1.982	3.003	2.792	1.027
RXHCC20	Lung, Kidney, and Other Cancers; Secondary Cancer of Lymph Nodes and Other Sites	0.456	0.335	0.936	0.683	0.258
RXHCC21	Lymphomas and Other Hematologic Cancers	0.332	0.123	0.329	0.234	0.123
RXHCC22	Prostate, Breast, Bladder, and Other Cancers and Tumors	0.120	0.123	0.257	0.234	0.123
RXHCC30	Diabetes with Complications	0.553	0.597	1.063	1.604	1.051
RXHCC31	Diabetes without Complication	0.203	0.187	0.390	0.546	0.433
RXHCC40	Alpha-1-Antitrypsin Deficiency	3.622	8.286	7.257	9.968	1.335
RXHCC41	Lysosomal Storage Disorders	2.729	12.200	2.283	18.255	0.212
RXHCC42	Acromegaly and Other Endocrine and Metabolic Disorders	1.859	3.535	2.476	5.639	0.695
RXHCC43	Pituitary, Adrenal Gland, and Other Endocrine and Metabolic Disorders	0.042	0.131	-	0.084	0.038
RXHCC44	Thyroid Disorders	0.068	0.153	0.145	0.276	0.136
RXHCC47	Disorders of Lipoid Metabolism	-	-	0.046	0.133	0.069
RXHCC54	Chronic Viral Hepatitis C	0.621	0.722	0.882	0.701	0.987
RXHCC55	Acute or Unspecified Viral Hepatitis C	0.621	0.722	0.882	0.701	0.987
RXHCC56	Chronic Viral Hepatitis B and Other Specified Chronic Viral Hepatitis	0.331	0.653	1.150	0.772	0.328
RXHCC59	Primary Biliary Cirrhosis	0.998	1.330	1.249	1.879	1.196
RXHCC65	Chronic Pancreatitis	0.319	0.582	0.534	0.847	0.526
RXHCC66	Pancreatic Disorders and Intestinal Malabsorption, Except Pancreatitis	0.221	0.582	0.443	0.847	0.298
RXHCC67	Inflammatory Bowel Disease	0.471	0.563	1.151	2.803	0.440
RXHCC80	Aseptic Necrosis of Bone	0.189	0.188	0.144	0.260	0.168
RXHCC81	Psoriatic Arthropathy	0.860	0.650	5.039	8.028	2.782
RXHCC82	Systemic Sclerosis	0.889	0.549	1.660	2.108	0.484
RXHCC83	Rheumatoid Arthritis and Other Inflammatory Polyarthropathy	0.245	0.308	1.237	2.108	0.484
RXHCC84	Systemic Lupus Erythematosus and Other Systemic Connective Tissue Disorders	0.092	0.192	0.207	0.289	0.098
RXHCC87	Osteoporosis, Vertebral and Pathological Fractures	0.050	0.180	0.205	0.377	-
RXHCC95	Sickle Cell Anemia	-	0.555	-	1.617	-
RXHCC96	Acquired Hemolytic, Aplastic, and Sideroblastic Anemias	0.687	0.520	0.752	0.948	0.187
RXHCC98	Hereditary Angioedema and Other Defects in the Complement System	11.920	55.843	16.691	51.928	0.644
RXHCC99	Immune Disorders	1.034	0.653	1.515	1.340	0.879
RXHCC100	Immune Thrombocytopenic Purpura	0.298	0.123	1.344	1.545	0.853
RXHCC111	Alzheimer's Disease	-	-	-	-	-
RXHCC112	Dementia, Except Alzheimer's Disease	-	-	-	-	-

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
RXHCC130	Schizophrenia and Other Psychosis	0.197	0.214	0.610	1.233	0.262
RXHCC131	Bipolar Disorders	0.197	0.105	0.494	0.633	0.262
RXHCC132	Depression	0.056	0.043	0.156	0.235	0.131
RXHCC133	Anxiety and Other Psychiatric Disorders	0.024	0.043	0.053	0.146	0.038
RXHCC146	Profound or Severe Intellectual Disability/Developmental Disorder	0.589	0.061	0.370	0.339	-
RXHCC147	Moderate Intellectual Disability/Developmental Disorder	0.589	-	0.170	0.098	-
RXHCC148	Mild or Unspecified Intellectual Disability/Developmental Disorder	0.589	-	0.031	-	-
RXHCC153	Myasthenia Gravis and Other Myoneural Disorders	1.011	2.341	1.600	2.387	0.348
RXHCC154	Amyotrophic Lateral Sclerosis and Other Motor Neuron Disease	0.764	1.382	0.430	1.559	0.114
RXHCC155	Spinal Cord Disorders	0.070	-	0.044	-	-
RXHCC157	Chronic Inflammatory Demyelinating Polyneuritis	3.773	6.672	5.451	7.959	1.746
RXHCC158	Inflammatory and Toxic Neuropathy	0.055	0.103	-	0.185	0.136
RXHCC159	Multiple Sclerosis	3.469	5.073	5.005	8.761	2.640
RXHCC160	Huntington Disease	2.974	3.714	3.265	5.292	3.217
RXHCC161	Parkinson Disease	0.491	0.788	0.493	0.754	0.475
RXHCC163	Intractable Epilepsy	0.292	0.424	0.724	2.597	0.395
RXHCC164	Epilepsy and Other Seizure Disorders, Except Intractable Epilepsy	0.052	-	0.014	0.146	-
RXHCC166	Migraine Headaches	0.083	0.116	0.229	0.276	0.363
RXHCC168	Trigeminal and Postherpetic Neuralgia	0.087	0.250	0.240	0.370	0.253
RXHCC183	Pulmonary Arterial Hypertension	1.082	3.791	1.575	5.934	0.575
RXHCC184	Pulmonary Hypertension, Except Arterial, and Other Pulmonary Heart Disease	0.171	0.293	0.213	0.381	0.238
RXHCC186	Heart Failure	0.137	0.053	0.213	0.136	0.238
RXHCC187	Hypertension	0.062	0.014	0.117	0.086	0.075
RXHCC188	Coronary Artery Disease	0.051	-	0.181	-	-
RXHCC191	Ventricular Septal Defect and Major Congenital Heart Disorders	0.103	0.677	0.381	0.292	0.363
RXHCC193	Atrial Arrhythmias	0.405	0.109	0.358	0.121	0.293
RXHCC207	Spastic Hemiplegia	0.160	0.115	0.156	-	-
RXHCC215	Venous Thromboembolism	0.336	0.323	0.375	0.419	0.342
RXHCC225	Cystic Fibrosis	3.705	19.887	2.132	24.380	1.119
RXHCC226	Idiopathic Pulmonary Fibrosis and Systemic Sclerosis with Lung Involvement	4.572	3.548	4.682	3.970	1.383
RXHCC227	Pulmonary Fibrosis, Except Idiopathic	0.358	0.481	0.481	1.172	0.392
RXHCC228	Severe Persistent Asthma	0.792	0.564	1.751	1.744	1.239
RXHCC229	Chronic Obstructive Pulmonary Disease, Bronchiectasis, and Other Asthma	0.210	0.088	0.452	0.357	0.392
RXHCC243	Glaucoma, Open-Angle or Moderate/Severe Stage	0.185	0.214	0.418	0.497	0.366

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
RXHCC244	Other Non-Acute Glaucoma	0.014	-	0.065	-	0.038
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	0.168	0.147	0.196	0.316	0.068
RXHCC314	Pemphigus, Pemphigoid, and Other Bullous Skin Disorders	0.303	0.935	0.473	0.962	0.262
RXHCC316	Psoriasis, Except with Arthropathy	0.182	0.192	1.291	2.464	0.848
RXHCC317	Discoid Lupus Erythematosus	0.065	0.115	-	-	-
RXHCC355	Narcolepsy and Cataplexy	1.021	2.256	1.364	3.376	0.762
RXHCC395	Stem Cell, Including Bone Marrow, Transplant Status/Complications	4.037	1.998	5.532	3.339	2.252
RXHCC396	Heart, Lung, Liver, Intestine, or Pancreas Transplant Status	-	-	-	-	-
Non-Aged Disease Interactions						
NonAged_RXHCC1	NonAged * HIV/AIDS	-	-	-	-	2.318
NonAged_RXHCC130	NonAged * Schizophrenia and Other Psychosis	-	-	-	-	0.698
NonAged_RXHCC131	NonAged * Bipolar Disorders	-	-	-	-	0.740
NonAged_RXHCC132	NonAged * Depression	-	-	-	-	0.368
NonAged_RXHCC133	NonAged * Anxiety and Other Psychiatric Disorders	-	-	-	-	0.026
NonAged_RXHCC159	NonAged * Multiple Sclerosis	-	-	-	-	3.241
NonAged_RXHCC163	NonAged * Intractable Epilepsy	-	-	-	-	0.651

NOTE: The Part D Denominator used to calculate relative factors is $2,275.97. 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 VI-6. 2025 RxHCC Model Relative Factors for New Enrollees, Non-Low Income (2018/2019 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	0.972	0.972	-	-
35-44 Years	1.221	1.221	-	-
45-54 Years	1.221	1.221	-	-
55-59 Years	1.221	1.221	-	-
60-64 Years	1.221	1.221	-	-
65 Years	0.384	1.232	1.075	1.232
66 Years	0.415	1.232	1.075	1.232
67 Years	0.426	1.232	1.075	1.232
68 Years	0.448	1.232	1.075	1.232
69 Years	0.480	1.232	1.075	1.232
70-74 Years	0.506	1.232	1.037	1.232
75-79 Years	0.577	1.232	0.781	1.232
80-84 Years	0.565	1.232	0.565	1.232
85-89 Years	0.565	1.232	0.565	1.232
90-94 Years	0.443	1.232	0.443	1.232
95 Years or Over	0.443	1.232	0.443	1.232
Male				
0-34 Years	1.148	1.148	-	-
35-44 Years	1.148	1.148	-	-
45-54 Years	1.148	1.148	-	-
55-59 Years	1.158	1.158	-	-
60-64 Years	1.158	1.158	-	-
65 Years	0.489	1.522	1.006	1.522
66 Years	0.516	1.522	0.989	1.522
67 Years	0.544	1.522	0.989	1.522
68 Years	0.556	1.522	0.970	1.522
69 Years	0.556	1.522	0.970	1.522
70-74 Years	0.637	1.522	0.970	1.522
75-79 Years	0.721	1.522	0.721	1.522
80-84 Years	0.721	1.522	0.721	1.522
85-89 Years	0.721	1.522	0.721	1.522
90-94 Years	0.400	1.522	0.400	1.522
95 Years or Over	0.400	1.522	0.400	1.522

NOTES:

1. The Part D Denominator used to calculate relative factors is $2,275.97. 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 VI-7. 2025 RxHCC Model Relative Factors for New Enrollees, Low Income (2018/2019 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	1.625	1.904	-	-
35-44 Years	2.402	2.402	-	-
45-54 Years	2.402	2.402	-	-
55-59 Years	2.012	2.257	-	-
60-64 Years	1.940	2.069	-	-
65 Years	1.117	2.025	1.629	2.025
66 Years	0.806	2.025	1.094	2.025
67 Years	0.750	2.025	1.094	2.025
68 Years	0.750	2.025	1.094	2.025
69 Years	0.750	2.025	0.978	2.025
70-74 Years	0.750	2.025	0.897	2.025
75-79 Years	0.709	2.025	0.709	2.025
80-84 Years	0.709	2.025	0.709	2.025
85-89 Years	0.709	2.025	0.709	2.025
90-94 Years	0.444	2.025	0.444	2.025
95 Years or Over	0.444	2.025	0.444	2.025
Male				
0-34 Years	1.377	1.932	-	-
35-44 Years	1.962	1.962	-	-
45-54 Years	1.962	1.962	-	-
55-59 Years	1.775	1.962	-	-
60-64 Years	1.632	2.018	-	-
65 Years	1.120	2.130	1.423	2.130
66 Years	0.790	2.130	0.909	2.130
67 Years	0.737	2.130	0.896	2.130
68 Years	0.737	2.130	0.896	2.130
69 Years	0.657	2.130	0.657	2.130
70-74 Years	0.657	2.130	0.657	2.130
75-79 Years	0.649	2.130	0.649	2.130
80-84 Years	0.649	2.130	0.649	2.130
85-89 Years	0.649	2.130	0.649	2.130
90-94 Years	0.350	2.130	0.350	2.130
95 Years or Over	0.350	2.130	0.350	2.130

NOTES:

1. The Part D Denominator used to calculate relative factors is $2,275.97. 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 VI-8. 2025 RxHCC Model Relative Factors for New Enrollees, Institutional (2018/2019 calibration, HCPCS-based filtering logic)

Variable	Not Concurrently ESRD	Concurrently ESRD
Female		
0-34 Years	3.753	2.633
35-44 Years	3.591	2.633
45-54 Years	3.511	2.633
55-59 Years	2.878	2.633
60-64 Years	2.846	2.633
65 Years	2.729	2.633
66 Years	2.729	2.633
67 Years	2.729	2.633
68 Years	1.760	2.633
69 Years	1.760	2.633
70-74 Years	1.622	2.633
75-79 Years	1.622	2.633
80-84 Years	1.273	2.633
85-89 Years	0.951	2.633
90-94 Years	0.743	2.633
95 Years or Over	0.556	2.633
Male		
0-34 Years	3.313	2.528
35-44 Years	2.939	2.528
45-54 Years	2.821	2.528
55-59 Years	2.726	2.528
60-64 Years	2.286	2.528
65 Years	2.372	2.528
66 Years	2.372	2.528
67 Years	1.769	2.528
68 Years	1.769	2.528
69 Years	1.769	2.528
70-74 Years	1.769	2.528
75-79 Years	1.582	2.528
80-84 Years	1.162	2.528
85-89 Years	0.971	2.528
90-94 Years	0.971	2.528
95 Years or Over	0.971	2.528

NOTES:

1. The Part D Denominator used to calculate relative factors is $2,275.97. 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 VI-9. 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

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
RXHCC19	Leukemias and Other Hematologic Cancers	2.138	1.919	2.960	2.733	0.986
RXHCC20	Lung, Kidney, and Other Cancers; Secondary Cancer of Lymph Nodes and Other Sites	0.444	0.328	0.921	0.659	0.267
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	0.089	0.194	0.207	0.281	0.100

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
	Systemic Connective Tissue Disorders					
RXHCC87	Osteoporosis, Vertebral and Pathological Fractures	0.050	0.180	0.203	0.381	-
RXHCC95	Sickle Cell Anemia	-	0.541	-	1.613	-
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

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
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
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	-	-	-	-	-

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
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, Transplant Status/Complications	4.116	2.064	5.597	3.362	2.178
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 VI-10. 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 VI-11. 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 VI-12. 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 VI-13. 2025 RxHCC Model with Disease Hierarchies (previously published in the 2023 Rate Announcement[99])

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:

[99] https://www.cms.gov/files/document/2023-announcement.pdf

1. This table applies to all of the RxHCC models in the 2025 Advance Notice.

How Payments are Made with a Disease Hierarchy:
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 VI-14. 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 VI-15. 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

Table VI-16. 2025 RxHCC Model Predictive Ratios by Deciles of Predicted Risk (sorted low to high): Continuing Enrollee Model Segments, 2018/2019 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	0.882	1.286	0.681	1.402	0.728
Second decile	1.227	1.329	1.207	1.353	0.922
Third decile	1.263	1.041	1.118	1.150	0.992
Fourth decile	1.244	1.053	1.037	1.077	1.026
Fifth decile	1.034	1.034	1.016	1.017	1.058
Sixth decile	0.960	0.981	1.027	0.956	1.049
Seventh decile	0.950	0.998	1.010	0.985	1.027
Eighth decile	0.942	0.957	0.981	0.926	1.016
Ninth decile	0.955	0.953	0.959	0.945	1.000
Tenth (highest)	1.012	0.992	0.997	1.005	0.979
Top 5%	1.015	0.998	1.003	1.001	0.975
Top 1%	1.017	0.993	1.023	1.074	0.985
Top 0.1%	0.933	1.028	0.990	1.051	1.061

Table VI-17. 2025 RxHCC Model Predictive Ratios by Deciles of Predicted Risk (sorted low to high): New Enrollee Model Segments, 2018/2019 calibration sample (HCPCS-filtered diagnoses)

Deciles	Non-Low Income	Low Income	Institutional
Entire sample	1.000	1.000	1.000
First (lowest) decile	0.939	1.002	1.007
Second decile	0.963	0.969	1.043
Third decile	1.057	1.013	0.997
Fourth decile	1.153	1.008	0.981
Fifth decile	0.973	1.004	0.985
Sixth decile	0.969	1.027	1.012
Seventh decile	1.033	1.000	1.013
Eighth decile	1.072	1.053	0.978
Ninth decile	1.001	0.947	0.992
Tenth (highest)	0.999	1.002	1.011
Top 5%	1.005	0.973	1.007
Top 1%	1.016	1.172	0.974
Top 0.1%	1.009	1.146	2.021

NOTE: For the non-low income and low-income new enrollee model segments, predictive ratios include beneficiaries with and without concurrent ESRD as well as those who are and are not originally disabled. 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. Originally Disabled is defined as originally entitled to Medicare by disability only (OREC = 1).

Attachment VII. 2024 CMS-HCC Model Predictive Ratio Tables

Table VII-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 VII-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 VII-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 VII-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 VII-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 VII-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 VII-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.