

# Issue Brief

FEDERAL ISSUE BRIEF



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## CMS Posts Calendar Year (CY) 2025 Advance Notice for Medicare Advantage (MA) and Part D Prescription Drug Programs

The Centers for Medicare & Medicaid Services (CMS) have released the Calendar Year (CY), 2025 Advance Notice of Methodological Changes for Medicare Advantage (MA), Capitation Rates and Part C and Part B Payment Policies.

A comment period ending March 1 is provided. A copy of the 186-page document is available at: <https://www.cms.gov/Medicare/Health-Plans/MedicareAdvvtgSpecRateStats/Announcements-and-Documents> and selecting "2025 Advance Notice."

Also included 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). CMS says it will announce the MA capitation rates and final payment policies for CY 2025 no later than April 1, 2024.

### Net Payment Impact

The chart below indicates the expected impact of the proposed policy changes on MA plan payments relative to last year. The chart is from CMS' 28-page fact sheet accompanying the notice.

**Year-to-Year Percentage Change in Payment**

Impact	2025 Advance Notice
Effective Growth Rate	2.44%
Rebasing/Re-pricing	TBD
Change in Star Ratings	-0.15%
MA Coding Pattern Adjustment	0.00%
Risk Model Revision and FFS Normalization	-2.45%
MA risk score trend	3.86%
<b>Expected Average Change in Revenue</b>	<b>3.70%</b>

Attachment I of the 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



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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, refer 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.

### **Comment**

There was significant discussion last year about the size of the Medicare risk adjustment. Much concerned it was too low and MA plans were being paid too much.

The notice contains a very detailed table of contents. The table is duplicated at the end of this analysis.

As noted above, CMS' fact sheet is 28 pages. Most of the material below is excerpted from the fact sheet.

### **Expected Average Change in Revenue**

#### ***Growth Rates***

The Effective Growth Rate reflects the current estimate of the growth in benchmarks used to determine payment for MA plans. This growth rate is largely driven by the growth in Medicare Fee-For-Service (FFS) per capita costs, as estimated by the Office of the Actuary.

Included in the 2025 growth rate estimate is a technical adjustment to the per capita cost calculations related to indirect and direct medical education costs associated with services furnished to MA enrollees. For CY 2025, CMS is proposing to continue the three-year phase-in of this technical adjustment finalized in the CY 2024 Rate Announcement. CMS proposes to apply 67 percent of the adjustment in CY 2025.

#### ***Part C Risk Adjustment Model***

CMS finalized an updated Part C Risk Adjustment Model in the CY 2024 Rate Announcement and began a three-year phase-in of the use of that model, referred to as the 2024 CMS-HCC (Hierarchical Condition Categories) model, starting with CY 2024. For CY 2025, CMS is proposing to continue phasing in the updated risk adjustment model.

#### ***MA Risk Score Trend***

The MA risk score trend is the average increase across plans in MA risk scores, not accounting for normalization and coding pattern adjustments to MA risk scores. The trend reflects increases in MA risk scores, which can be due to several factors, including changes in demographics and coding patterns. The trend is an industry average and individual plans' experience will vary. CMS calculated the MA risk score trend for each model used in the payment year separately and blend based on the phase-in of the updated model. The risk score trend is 3.30 percent under the 2024 CMS-HCC model and 5.00

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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.

### ***Inflation Reduction Act (IRA) Updates for 2025***

Part D benefit-related IRA updates will be in place for CY 2025 and are described in the Advance Notice and related Draft CY 2025 Part D Redesign Program Instructions include the elimination of the coverage gap phase to affect a three-phase benefit (deductible, initial coverage, and catastrophic) and cap out-of-pocket costs at \$2,000 for CY 2025. Other previously implemented IRA benefits will continue, including no cost sharing for enrollees in the catastrophic phase, a \$35 monthly cap on enrollee cost sharing for each covered insulin product, and no cost sharing for adult vaccines recommended by the Advisory Committee on Immunization Practices that are covered under Part D.

For more details, please see the Fact Sheet for the Draft CY 2025 Part D Redesign Program Instructions available at <https://www.cms.gov/files/document/draft-cy2025-part-d-redesign-program-instruction-fact-sheet.pdf>.

### **Frequently Asked Questions (FAQs) on the 2025 Medicare Advantage and Part D Advance Notice**

The 28-page fact sheet discusses changes via questions as shown below.

#### **MEDICARE Advantage**

##### **1. How would the proposed changes in the 2025 Advance Notice impact payments to MA plans?**

MA payments from the government to MA plans are expected to increase by 3.70 percent on average from 2024 to 2025. This is over a \$16 billion increase in expected MA payments for next year. This expected increase includes consideration of the various elements that impact MA payment, such as growth rates of underlying costs, 2024 Star Ratings for 2025 quality bonus payments, continued phase-in of risk adjustment model updates that were implemented in CY 2024, and increases to risk scores because of MA risk score trend, which can be driven by a number of factors including MA demographics and coding patterns.

##### **2. How will the proposed changes impact individuals' MA premiums and benefits in 2025?**

CMS anticipates stable premiums and benefits for individuals for CY 2025, as was the case for offerings in CY 2024, which was the first year of the updated risk adjustment model implementation.

##### **3. What are the updates for MA risk adjustment for CY 2025?**

CMS proposes to continue implementing the three-year phase-in of the updated Part C Risk Adjustment model, referred to as the 2024 CMS-HCC model. CY 2025 will be the second year of the phase-in, and CMS proposes to blend 67 percent of the risk score calculated using the updated 2024 MA risk adjustment model with 33 percent of the risk score calculated using the 2020 MA risk adjustment model.

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

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(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.

#### **4. How does the continued phase-in of the updated risk adjustment model impact dually eligible individuals?**

CMS is committed to ensuring that all MA individuals, including dually eligible individuals and Special Needs Plans (SNP) enrollees, can access the care they need and that plans are paid accurately for the care they provide. Payment accuracy ensures MA plan payments better reflect the expected costs of care, with higher payments going to plans serving people with greater health care needs, including individuals dually eligible for Medicare and Medicaid.

CMS has concluded that continuing to implement the 2024 CMS-HCC model is necessary and appropriate and increases predictive accuracy of the risk adjustment model for these individuals. For reference, CMS has included in Attachment VII of the CY 2025 Advance Notice the 2024 CMS-HCC model predictive ratios that were published in the 2024 Rate Announcement, which shows improved predictive ratios across segments, including for enrollees entitled to Medicare because of age or disability who are dually eligible for Medicaid and Medicare.

CMS calculated the MA risk score trend for dually eligible individuals (i.e., full-benefit and partial-benefit dually eligible people residing in the community) and found that this trend is 4.33 percentage points higher than it is for non-dually eligible individuals accounting for the increased blend

The risk adjustment model does not set payments to plans and does not reimburse plans for specific conditions. Plan bids project the average revenue needed to cover all Part A and B benefits, and the risk score adjusts this amount based on the health status of a plan’s enrollee population. CMS says the 2024 CMS-HCC model will accurately predict the differential between individuals who are expected to have low and high risk. If a specific HCC (or diagnosis code mapped to a specific HCC) is no longer included in the payment model, coefficients of other HCCs and demographic factors will be increased such that the model continues to predict the overall total expenditures.

#### **5. What is the impact of the updated MA risk adjustment model on enrollees with complex needs and preventive care?**

As stated in the 2024 Rate Announcement, the function of the CMS-HCC model is to minimize incentives for MA plans to compete for the healthiest individuals. To accomplish this objective, the risk adjustment model accurately predicts relative risk across subgroups of individuals and pays plans more for populations that have more complex health needs. For 2024, CMS updated the model to reflect the ICD-10 classification system, which has been used by the health care industry since 2015, and more recent underlying cost and utilization patterns to improve risk prediction.

#### **6. Why are some diagnosis codes that were in the 2020 CMS-HCC model not in the 2024 CMS-HCC model?**

CMS had to complete a reclassification to align the underlying HCCs with the ICD-10 classification system and risk adjustment principles. The MA risk adjustment models are based on diagnosis code groupings (called HCCs, Hierarchical Condition Categories) that are clinically related and have similar

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ability to predict Medicare costs. While all roughly 74,000 diagnosis codes are mapped to an HCC, only a subset of HCCs are included in the model for payment following well-established principles to determine which HCCs best predict Medicare costs. CMS developed the HCCs using empirical evidence on frequencies and predictive power; clinical input on relatedness, specificity, and severity of diagnoses; and professional judgment on incentives and diagnostic patterns relative to the classification system. Since the health care system transitioned to ICD-10 in 2015, the codes coming in from plans to CMS were ICD-10 codes, but before CMS could reclassify the HCCs in accordance with the ICD-10 classification system, CMS needed to wait for ICD-10 diagnosis and coding practices, treatment methods, and costs to stabilize.

In the finalized 2024 model, there were 115 HCCs in the payment model and 151 HCCs that were not in the payment model. It is typical that most HCCs are not in the payment model. The 2020 CMS-HCC model included 9,797 ICD-10 codes for payment or 13 percent of ICD-10 codes. The finalized 2024 CMS-HCC model included 7,770 ICD-10 codes, or 10.5 percent of ICD-10 codes.

The transition from ICD-9 to ICD-10 accounted for roughly 97 percent of the codes that were not included in the 2024 CMS-HCC payment model.

### **7. Why does the 2024 CMS-HCC model include fewer diagnosis codes for mental health conditions than the 2020 CMS-HCC model?**

Because the ICD-10 classification system differed significantly from ICD-9 for mental health diagnosis codes, the mental health HCCs were reconstructed, and certain diagnosis codes that are not consistent predictors of costs, like mild depression in remission, were mapped to non-payment HCCs. The majority (the remaining 350) of these codes were kept in the payment model. Updating this HCC mapping does not mean that MA plans and contracted providers are no longer required to treat mild depression or other codes that map to non-payment HCCs; MA plans are required to provide all Medicare Part A and B-covered services (subject to limited exclusions). The update merely means that based on cost data, those diagnoses are not stable predictors of prospective cost and, thus, should not increase payments to MA plans.

### **8. Why does the 2024 CMS-HCC model include fewer diagnosis codes for diabetes than the 2020 CMS-HCC model?**

As part of updating the risk adjustment model, certain diabetes codes no longer map to payment HCCs because they are not consistently reliable predictors of costs. However, over 300 diabetes codes remain in the risk adjustment model. Additionally, in the updated model, CMS is making the same adjustment for diabetes across all Diabetes HCCs (HCC 36, 37, and 38). In the 2020 CMS-HCC model, the top two diabetes HCCs, 17 and 18, were already constrained. When developing the 2024 CMS-HCC model, empirical data showed that in the 2020 CMS-HCC model, HCC 18 had a substantially higher prevalence in MA than FFS, and HCC 19 had a lower prevalence; the shift of individuals to a higher HCC in the hierarchy led to further evaluation of the diabetes HCCs.

### **9. What is FFS normalization?**

At a high level, the purpose of FFS normalization is to account for trends in the FFS risk scores between the last time the model was recalibrated with new FFS data and the MA payment year.

CMS applies an FFS normalization factor to MA risk scores in the payment year to account for this trend in the average FFS risk score between the denominator year risk score and the payment year.

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The FFS normalization factor is a projection of this average FFS risk score trend, and CMS applies the factor by dividing each individual MA risk score in the payment year by the normalization factor.

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 information available at the time the normalization factor is calculated. By setting the average FFS risk score to 1.0, CMS says it ensures that the risk scores used to pay MA organizations align with the risk scores used to set the MA benchmarks. CMS calculates benchmarks based on the average county-level FFS risk score that has been adjusted so that the overall FFS risk score across all counties is 1.0.

#### **10. What is CMS considering regarding the FFS normalization calculation methodology for CY 2025?**

CMS has 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 more reasonable projections of what the actual average FFS risk score will be in the payment year.

In CY 2025, for both MA and PACE End-Stage Renal Disease (ESRD) and Non-ESRD risk adjustment models, CMS is proposing to use a multiple linear regression methodology that incorporates historical FFS risk scores from the most current five years of average FFS risk scores and includes a flag that identifies whether a risk score is based on dates of service before 2020 or dates of service starting in 2020 after the onset of the COVID-19 pandemic to calculate the normalization factors.

#### **11. How do the risk adjustment model updates and FFS normalization interact to result in a negative 2.45 percent?**

When CMS updates a CMS-HCC risk adjustment model, it may make a variety of updates, including updates to the underlying FFS diagnosis and expenditure data to use more recent years, which allows the model coefficients to reflect more recent costs and coding trends, revisions to the Conditions Categories in the model to improve predictive accuracy of the model, and update the denominator year, which brings the year in which the 1.0 FFS risk score is set to a more recent year.

The denominator update will have a direct impact on the normalization factor, which serves the purpose of keeping the average FFS risk score at 1.0 in each payment year. After a risk model is implemented, there will be a trend in the risk scores calculated with that model over a period of years due to changes in population and coding practice compared to the denominator year. Therefore, for each payment year, CMS calculates a normalization factor for each model to project the average FFS risk score from the denominator year to the payment year. CMS applies this normalization factor to all risk scores from that model to account for underlying trends in FFS coding and population from the denominator year to the payment year and keep the average FFS risk score at the same average (1.0).

#### **12. What is the technical adjustment being phased in related to medical education costs?**

CMS finalized a technical adjustment to the growth rates related to medical education costs in the CY 2024 Rate Announcement and began phasing in the adjustment starting with CY 2024. Included in the CY 2025 Advance Notice is a proposal to continue phasing in the technical adjustment to the per capita cost calculations that result in a reduction in the growth rates. Historically, prior to the CY 2024 MA



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rates, the tabulation of per capita costs for FFS individuals had included indirect medical education and graduate medical education costs paid by CMS to inpatient facilities associated with services furnished to MA enrollees because CMS had not been able to separately identify these payments from those made for services furnished to FFS individuals. The baseline modeling supporting the growth rate calculations was updated to enable CMS to identify the historical and projected costs of medical education paid by CMS for MA admissions. CMS proposes to apply 67 percent of the adjustment for MA-related medical education costs in CY 2025.

### **13. What drives the Medicare Advantage payment Growth Rates?**

As required by statute, the growth rates used in the calculation of the MA rates reflect the growth in per capita costs for non-ESRD individuals enrolled in either FFS or Medicare health plans. The growth rates are based on the expected change in United States Per Capita Costs in Fee-For-Service (FFS USPCC) and in Medicare overall (both FFS and MA) and, as such, are largely driven by trends in per capita costs for individuals in Medicare FFS. The main driver of the Effective Growth Rate is the FFS USPCC, with the Total USPCC used to calculate the Pre-ACA benchmark cap amount for each county..

### **14. Why is the MA risk score trend so important to understanding year-over-year impacts?**

While not a policy proposal, the MA risk score trend is a key factor in the level of overall MA payments. The MA risk score trend accounts for the average annual increase in MA risk scores and is driven by MA demographics and diagnosis coding patterns.

### **15. How does CMS calculate the MA risk score trend?**

CMS calculates the MA risk score trend by using MA risk scores over three prior years and then calculating the average annual change in risk scores across those three years. For CY 2025, the MA risk score trend was calculated using MA risk scores from 2018 through 2020, before MA risk score data was impacted by the pandemic. Because risk scores are calculated from prior year diagnoses, the 2020 risk scores (based on 2019 diagnoses) were minimally affected by the disruption resulting from the COVID-19 pandemic. Our analysis finds that 2020 risk scores are appropriate to include in the risk score trend.

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.

## **MEDICARE Part D**

### **16. What proposals does CMS provide for the Part D Benefit in the CY 2025 Advance Notice?**

In the CY 2025 Advance Notice, CMS provides information on the Part D benefit parameters that are to be updated or eliminated because of amendments to the Social Security Act made by the ***Inflation Reduction Act of 2022*** (IRA).

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**17. Has CMS updated the Part D risk adjustment model to reflect the redesign of the Part D benefit?**

The updated model being proposed uses the most recent available data for model calibration, which CMS believes best reflects what the patterns in drug spending will be in 2025.

**18. Which years of data did CMS use to calibrate the Part D risk adjustment model?**

For MA-PDs and standalone PDPs, the proposed Part D risk adjustment model is calibrated on 2021 diagnoses to predict 2022 expenditures. For PACE organizations, the proposed Part D risk adjustment model is calibrated on 2018 diagnoses to predict 2019 expenditures.

**19. What change is CMS proposing for Part D normalization?**

CMS is proposing to maintain the existing linear slope methodology for calculating Part D model normalization factors—which is to calculate a slope using five years of risk scores and then projecting the slope by the number of years between the denominator year to the payment year—but to do this calculation separately for MA-PD plans and PDPs.

**20. Why is CMS not proposing the multiple linear regression methodology for Part D normalization?**

The risk scores used in the trend to calculate the Part D normalization factors are the five most recent MA-PD risk scores and the five most recent years of PDP risk scores available. 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).

Because CMS does not have a 2023 risk score for the RxHCC normalization factor calculation, CMS says it cannot yet evaluate the accuracy of the linear regression approach.

**21. Does the revised Part D risk adjustment model accurately predict cost for individuals with a low- income subsidy?**

The proposed Part D risk adjustment model update reflects the changes to plan cost sharing for low-income individuals as part of the IRA Part D benefit design. Risk scores for low-income individuals are expected to increase because plan liability for these individuals are expected to increase more than it does for non-low-income individuals.

**23. Does the revised Part D risk adjustment model accurately predict for individuals using high-cost drugs?**

Yes, CMS presents predictive ratios for the proposed Part D risk adjustment model in the Advance Notice, and its analysis found that the new model generally predicts well for individuals with the highest predicted risk.

**24. Will software or risk scores be posted to the CMS website so that plans can evaluate the impact of the new Part D risk adjustment model?**

Model software and risk scores for the proposed Part D risk adjustment model will be posted when the Advance Notice is published. Specifically, CMS will post software for the Part D risk adjustment models presented in the Advance Notice and risk scores for three versions of the Part D model for MA-PDs and



PDPs: 1) the current Part D model (first implemented for payment in 2023), 2) the proposed 2025 Part D model (2021/2022 calibration), and 3) an alternate calibration of the 2025 Part D model (2018/2019 calibration). CMS will also include risk scores for two versions of the PACE RxHCC model: 1) the current Part D model (first implemented for payment in 2020) and 2) the proposed 2025 Part D model (2018/2019) calibration.

**Comment**

We have been critical of CMS’ failure to provide tables of contents and page numbers. This notice demonstrates that CMS can do such. Let’s hope more rules provide this important and helpful information.

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