NovaRest, Inc.

Summary of Advance Notice of Methodological Changes for Calendar Year (CY) 2025

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Executive Summary

The Centers for Medicare & Medicaid Services (CMS) Advance Notice of Methodological Changes for Calendar Year (CY) 2025 for Medicare Advantage (MA) Capitation Rates and Part C and Part D Payment Policies was recently released[1] accompanied by a summary fact sheet.[2] This is a particularly technical annual release which provides significant detail into model factors, however, this summary will primarily discuss the content related to growth percentages and MA/PD payment parameters changes proposed for the upcoming Calendar Year.

The Advanced Notice goes into detail regarding the underlying methodology used to determine growth rates, which we do not believe have changed significantly from the prior Advanced Notice. Items of interest include the impact on growth rates related to the continuation of the phase-in of the removal of medical education expenditures from growth rates, COVID-19 impacts, Inflation Reduction Act (IRA) impacts, and more information regarding the Supreme Court decision related to the 340B drug program.

Regarding the MA/Program of All-Inclusive Care for the Elderly (PACE) payment methodology, CMS proposed changes to the data and methodology used to calculate Direct Graduate Medical Education (DGME) and Indirect Medical Education (IME) carve outs for hospitals participating in the Maryland Total Cost of Care (TCOC) Model, which allowed Maryland to set rates for Inpatient Prospective Payment System (IPPS) and the Outpatient Prospective Payment System (OPPS) services and impacts the CMS system data used to develop the DGME and IME carve-outs. CMS also proposed reducing provider incentive payments for participation in the Advanced Alternative Payment Model to 3.5% for CY2025. 2025 is also proposed to be the second year of the phase-in for an updated risk adjustment model, referred to as the 2024 CMS-HCC model, which is expected to be fully implemented in 2026. This phase-in will also impact CMS' proposed frailty scores which will be based on a blend of the 2020 and 2024 HCC models.

The IRA provisions will impact the Part D payment methodology significantly in CY 2025, as the closing of the gap phase will make the Defined Standard a three-phase benefit with a maximum annual OOP threshold of $2,000. Additionally, the Coverage Gap Discount Program (CGDP) will be replaced by the new Discount Program, which will continue to require manufacturer discounts which will be provided through the initial coverage phase.

[1] https://www.cms.gov/files/document/2025-advance-notice.pdf

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

Preliminary Estimates of the National Per Capita Growth Percentage and the National Medicare Fee-for-Service Growth Percentage for Calendar Year 2025

In the 2025 Advanced Notice, CMS released their estimates of the change in the United States Per Capita Costs (USPCCs) for 2024 to 2025 which are used in the calculation of MA benchmarks as well as goes into detail on the methodology used to calculate the USPCCs.

Indirect Medical Education (IME) and Direct Graduate Medical Education (DGME) Adjustments

CMS noted in the Advanced Notice, that they intend to continue the 3-year phase in process for removing IME and DGME from historical and projected expenditures supporting the non-ESRD FFS USPCCs which began in CY 2024. These expenditures are payments that are intended to come from the Secretary and not FFS beneficiaries, however, they had historically been included in non-ESRD FFS USPCCs because experience did not separately identify these payments. No impact is expected on the ESRD USPCCs. The phase in is as below:

- In CY 2024, 33% of the MA-related medical education adjustment applied to the USPCCs.
- In CY 2025, they are proposing to apply 67% of the MA-related medical education adjustment.
- Expecting to use 100% in CY 2026.

With the 67% adjustment, the CY 2025 FFS growth rate is estimated at 2.57%. Table I-2. Increase in the USPCC Growth Percentage for CY 2025 from the Advanced Notice is provided below:

	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%

COVID-19

CMS' estimates continue to 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. $0 cost sharing will continue to apply for a COVID-19 vaccine and its administration in 2025.

Part B Provisions of the Inflation Reduction Act (IRA)

Estimates also consider Part B provisions of the IRA that are effective. These are not new provisions, but as a reminder, some of these provisions include:

- Require manufacturers 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.
- 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.

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

The Supreme Court decided against HHS's reduction in provider reimbursement rates in the American Hospital Association v. Becerra case. As a result, CMS will make a one-time lump sum payment to each affected provider to reflect the difference between what was paid and what would have been paid had the 340B payment policy not been applied. CMS will budget neutralize the remedy, by reducing non-drug outpatient item and service prospective payments beginning in 2026.

2025 USPCCs and 2025 growth rates are not expected to be impacted, as the lump sum remedy payments are reflected in the USPCCs of the respective year associated with the service experience. USPCCs for years 2026 and later will reflect the reduction for non-drug outpatient item and service prospective payments by 0.5 percent per year until the entire offset is reached.

Loading for Claims Processing Costs

CMS 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. The loading continues to be developed as the ratio of MAC administrative costs to Medicare benefit payments for the most recently completed fiscal year.

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

MA Benchmark, Quality Bonus Payments, and Rebate

For 2025, CMS intends update county FFS costs using more recent information as part of the calculation of the rates in a process called rebasing. CMS is required to rebase periodically but have rebased every year since 2012. The rebasing is particularly important in the calculation of the specified and applicable amounts which are used to determine the MA benchmark. More information on this process is discussed in the Advanced Notice. The benchmark (post QBP percentage rate) will continue to be capped at the level of a county's applicable amount. Additionally, we note that PACE payment rates are not developed using the specified amount, but do use the applicable amounts.

Because the most recent rebasing year was 2024, CMS noted the quartile applicable percentages are based on the FFS county rate rankings for 2024. This methodology appears unchanged, but the ranking is based on an updated year.

The Quality Bonus Payment Percentage methodology does not appear to have changed. This refers to the quality bonus payments CMS makes to MA organizations that meet quality standards measured under a five-star quality rating system. It also determines which service area benchmarks MA plans bid against. Contracts with fewer than 4 stars will continue to receive a 0% QBP add-on to the percentage for the benchmark in each county in the service area. Contracts with 4 stars and greater will receive 5% QBP add-on, except for new MA plans and low enrollment plans which will receive a 3.5% QBP add-on. For counties that are considered qualifying counties, the QBP add-on is doubled; however, the post-QBP percentage rates must be capped at the applicable amount. Contracts with the same plan type under the same legal entity that are combined will use an enrollment weighted average QBP rating.

The rebate methodology does not appear to have changed from the prior year. The level of rebate for each plan is also based on the plan's Star Rating (except for Medical Savings Account (MSA) plans), and are calculated as a percentage of the amount by which the risk-adjusted service area benchmark exceeds the risk-adjusted bid. The rebate may be applied to pay for mandatory supplemental benefits and/or to buy down beneficiary premiums for Part B and/or Part D prescription drug coverage. CMS intends to treat low enrollment plans as having a Star Rating of 3.5 stars for purposes of determining the rebate percentage.

CMS intends to release a list of the qualifying counties for the Qualifying County Bonus Payments with the final 2025 Rate Announcement.

Calculation of Fee for Service Cost

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). CMS noted their intent to improve their development of the AGAs and FFS per capita costs.

Consistent with prior years, CMS does not propose to reprice Part B drugs and will continue to adjust the uncompensated care payments (UCP) represented in the 2018 2022 claims.

CMS indicated they will continue to adjust historical FFS experience for shared savings or experience with the Medicare Shared Savings Program and Innovation Center models and demonstrations. Incentive payments will continue to be paid for providers qualifying through sufficient participation in an Advanced Alternative Payment Model. The payment in 2025 is 3.5 percent, down from 5 percent in 2019-2024.

CMS is considering whether to include an adjustment to the FFS experience for beneficiaries enrolled in Puerto Rico with zero claims. An adjustment was applied in the past, but they are seeking comment on continuing an adjustment. In the prior analysis 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.

Adjustments to the AGAs Section

The AGA Methodology used to determine the CY2025 ratebook will be based on non-hospice Medicare FFS claims data from 2018-2022.

The calculation of the DGME carve-out for CY 2025 for non-Maryland facilities is the same as used for CY 2024. However, CMS is proposing to revise the data and methodology used to develop the DGME carveout for hospitals participating in the Maryland Total Cost of Care (TCOC) Model, which sets a per capita limit on Medicare total cost of care in Maryland. A full explanation of the methodology is explained in the Advanced Notice.

CMS expects to publish the DGME carve-out factors for the 2025 rates with the 2025 Rate Announcement.

The 21st Century Cures Act 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. However, this did not discuss PACE so PACE organizations must continue to cover organ acquisition costs for kidney transplants. 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 described in the Advanced Notice. The KAC carve-out factors for the 2025 rates will be published with the 2025 Rate Announcement. CMS noted they do not have data to develop a KAC carve-out specifically for Maryland hospitals for CY2025.

Payment to teaching facilities for IME expenses associated with MA plan enrollees will continue to be paid directly by CMS to hospitals. 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, with the maximum reduction for any specific county in 2025 being 9.6 percent of the FFS rate. The IME payment phase-out does not apply to PACE capitation rates. CMS proposed to revise the data and methodology used to develop the IME carveout for hospitals participating in the Maryland TCOC Model and is described in the Advanced Notice.

MA ESRD Rates

CMS proposes to continue to their methodology for setting MA ESRD rates on a state basis using updated (2018-2022) FFS costs for 2025. The removal of GME expenses and phase-out of IME expenses will also apply to the MA ESRD rates. More information is expected to be published in the CY 2025 Rate Announcement.

The ESRD rates for PACE in 2025 will continue to include KACs and IME amounts.

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.

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

Non-employer MA PFFS plans in network areas must enter into signed contracts with a sufficient number of providers to meet the access standards. Network areas for plan year 2026 are expected to be released with the CY 2025 Rate Announcement.

MA Employer Group Waiver Plans (EGWP)

CMS intends to continue to waive the bidding requirements for all MA employer/union-only group waiver plans (EGWPs) for 2025. CMS will establish MA EGWP payment amounts using the same methodology for 2025 as was used for 2024 which is described in the Advanced Notice.

CMS-HCC Risk Adjustment Model for CY 2025

CMS will continue to phase in an updated risk adjustment model, referred to as the 2024 CMS-HCC model, in 2025. Full implementation is expected in 2026. Risk scores for CY 2025 are proposed to use 33 percent of the 2020 CMS-HCC model and 67 percent of the 2024 CMS-HCC model. The MA risk score trend for CY 2025 is 3.86 percent calculated using MA risk scores from 2018 through 2020 using the blended models.

For PACE organizations, CMS proposes to continue to use the 2017 CMS-HCC model to calculate risk scores.

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

For CY 2025, for MA plans, CMS will continue to use the 2023 ESRD risk adjustment models and for PACE organizations, CMS will continue to use the 2019 ESRD risk adjustment models.

Frailty Adjustment for PACE Organizations and FIDE SNPs

CMS uses a frailty adjustment to predict the Medicare expenditures of community populations with functional impairments that are unexplained by the diagnoses in the CMS-HCC model. Additionally, CMS is required to take into account the frailty of the PACE population when establishing the capitated payment amounts for PACE organizations. CMS may also take into account the frailty of beneficiaries enrolled in Fully Integrated Dual Eligible Special Needs Plans (FIDE SNPs).

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 (33% of 2020 CMS-HCC model frailty and 67% of 2024 CMS-HCC model frailty). Additionally, 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. 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.

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

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.

Normalization Factors

CMS is proposing a more sophisticated multiple linear regression methodology for calculating all FFS normalization factors for CMS-HCC models for CY 2025.

Normalization Factors for the CMS-HCC Models

Model	Proposed 2025 Normalization Factor
2024 Part C CMS-HCC Model	1.045
2020 Part C CMS-HCC Model	1.153
2017 Part C CMS-HCC Model	1.157
2023 ESRD Dialysis CMS-HCC Model	1.044
2019 ESRD Dialysis CMS-HCC Model	1.103
2023 ESRD Functioning Graft Model	1.074
2019 ESRD Functioning Graft Model	1.159

Sources of Diagnoses for Risk Score Calculation for CY 2025

CMS proposed to not change the method calculate risk scores for payment to MA organizations (PACE and non-PACE).

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

The Advanced Notice discusses the updated Defined Standard parameters and discusses any proposed changes to the payment methodology for 2025. The Advanced Notice also touches on the impact of the IRA provisions in 2025. While CMS acknowledges they are primarily addressing IRA provisions that impact the statutory parameters for 2025, they provided a good summary of the IRA provisions.

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 annual percentage increase (API) in the Consumer Price Index (CPI).
- 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. 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 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.

Annual Adjustments to Medicare Part D Benefit Parameters in 2025

The defined standard Part D prescription drug coverage in CY 2025 will consist of three-phases

• Annual deductible: Beneficiaries will be responsible for all of their Part D prescription drug costs in this phase, up to the deductible limit of $590 for 2025. CMS notes that the deductible does not apply to any Part D covered insulin product and any Advisory Committee on Immunization Practices (ACIP) recommended adult vaccine.

• Initial coverage phase: Beneficiaries pay 25% coinsurance for most covered Part D drugs. The initial coverage phase will extend to the maximum annual OOP threshold of $2,000. This is down from $8,000 in 2024, and will be increased by API going forward.

• Catastrophic coverage phase: Beneficiaries will continue to pay no cost sharing for covered Part D drugs in the catastrophic coverage phase.

CMS noted the categories of payments that count toward TrOOP (which determines when a beneficiary meets the OOP threshold) will change in CY 2025. Specifically, TrOOP will include previously excluded supplemental benefits and exclude Discount Program payments.

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.

The percent increase in the maximum copayments indexed to the CPI for CY 2025 is 2.50 percent. 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.

Continuing in 2025 is that beneficiaries in resource category 4 (with incomes between 135 and 150 percent of the FPL, who meet the resource standard, 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 (Non-institutionalized FBDE beneficiaries with incomes between 100% and 150% of FPL and full-subsidy-non-FBDE beneficiaries.) in CY 2025. Category 2 (Non-institutionalized FBDE beneficiaries with incomes up to 100% of the FPL) and 3 (FBDE beneficiaries who are institutionalized or would be institutionalized if they were not receiving home and community-based services) of the LIS remain unchanged.

CMS provided the following table regarding LIS cost-sharing parameters in Table III-7 of the Advanced Notice:

	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

Sunset of the Coverage Gap Discount Program and Establishment of the Manufacturer Discount Program

Effective January 1, 2025, the new Discount Program will replace the CGDP. The new Discount Program requires manufacturers to provide discounts on applicable drugs in the initial coverage phase (typically 10% discount on applicable drugs) and catastrophic phase (typically 20% discount on applicable drugs) of the defined standard Part D drug benefit. Some manufacturers may be eligible to be a "specified manufacturer" or "specified small manufacturer", which changes the discounts they are required to provide. The program applies to applicable drugs dispensed to both LIS and non-LIS beneficiaries.

Part D Premium Stabilization

Consistent with last year 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 increased by 6%, or $36.78. More information will be provided when the CY2025 bids have been submitted.

Part D Calendar Year EGWP Prospective Reinsurance Amount

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.

Part D Risk Sharing

CMS widening the risk corridor would increase the risk associated with providing the Part D benefits, and while narrowing would reduce the risk although CMS cannot narrow corridors relative to CY 2011 thresholds. CMS indicated will not change the current threshold risk percentages for CY 2025.

The risk percentages for the first and second thresholds remain at +/- 5 percent and +/- 10 percent of the target amount, respectively, for CY 2025. The payment adjustments for the first and second corridors are 50 percent and 80 percent, respectively.

Retiree Drug Subsidy Amounts

The IRA did not change the statutory requirements for retiree drug subsidy plans. The cost threshold and cost limit are defined as $590 and $12,150 for plans that end in CY 2025.

RxHCC Risk Adjustment Model

Due to the significant benefit changes, CMS recalibrated the RxHCC model to account for these changes and improve the model's accuracy under the 2025 Part D benefit. Additionally, oral ESRD drugs that will be covered by Part B in 2025 were removed from the RxHCC model. A thorough explanation is provided in the Advanced Notice and Table III-9 of the Advanced Notice provides a good summary of changes that were considered in improving the models accuracy.

Normalization Factors for the RxHCC Models

Due to the significant benefit changes from the IRA, as well as significant enrollment growth in MA plans, CMS proposed to apply separate normalization factors for MA-PD plans vs PDPs, using the existing five-year linear slope methodology.

For Non-PACE: 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. 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.

PACE: Using CMS's historical five-year linear slope methodology and average risk scores from 2016-2020 (2021 and 2022 were not used due to lack of data due to the change to diagnosis data solely from encounter data), the normalization factor is 1.163, which is the factor calculated for MA PD plans.

CMS does not propose to change the sources of diagnoses used to calculate Part D risk scores for either PACE or non-PACE.