Viewpoints on the 2025 CMS Advance Notice

On January 31, 2024, the Centers for Medicare & Medicaid Services (CMS) released the 2025 Advance Notice for Medicare Advantage (MA) and Part D plan sponsors ("health plans"), along with a draft of 2025 Part D Redesign Program Instructions. As always, these changes contain a mix of both opportunities and challenges that plans will need to assess and develop strategies to address. Most importantly, commentary about general impact can vary greatly based on specific plan circumstances. Comments on the 2025 MA and Part D Advance Notice issued on January 31 are due by March 1, 2024.

Please keep in mind that rates and other information contained in this guide are preliminary and subject to change. Final rates are expected by April 2024.

On November 6, 2023, CMS released the 2025 Medicare Advantage and Part D Proposed Rule (CMS-4205-P). The proposed rule serves as a context for many of the changes noted for the Star Ratings program in the Advance Notice as well as reinforces the "patient-first" focus while "creating incentives to eliminate health disparities." Comments on the policy and technical changes published November 6 were due by January 5, 2024.

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6 key proposed changes for 2025

1 **Estimated MA and fee-for-service (FFS) effective growth rate of 2.44%.** The growth rate is driven by indirect medical education (IME) and direct graduate medical education (DGME) costs' continued removal from historical and projected expenditures, along with 2024 and 2025 trends decreasing relative to CMS's estimates last year.

See Part C plan payment →

2 **The CMS-HCC risk model revision and risk score normalization updates are estimated to decrease average plan payments by 2.45%.** When considered against the effective growth rate, this results in a 0.01% decrease in payments. Actual results will vary significantly by county and plan.

See Part C plan payment →

3 **CMS is proposing a new multiple linear regression methodology for predicting CMS-HCC normalization factors.** This new methodology would replace the linear slope methodology that CMS has used since 2007.

See risk adjustment →

4 **The key theme for the 2025 Star Ratings update is promoting a whole-person care model by leveraging a "Universal Foundation" to introduce future Star Ratings measures.** This is to drive the patient-centricity and equity core component of this model as noted in the "Display Measures" and "Potential New Measure Concepts" sections. CMS is requesting stakeholder input on the proposed concepts to further engage in the rulemaking process. The rulemaking will formally introduce these concepts in Star Ratings program.

See Star Ratings program →

5 Changes to the Part D program include those signed into law by the Inflation Reduction Act (IRA) of 2022. This includes the **elimination of coverage gap phase in in CY 2025.**

See Part D program changes →

6 **Proposed changes to the RxHCC model** are intended to better align with the 2025 Part D benefit design, through re-adjudication of PDE data and recalibration of model coefficients.

See Part C plan payment →

Part C plan payment

Highlights of proposed changes

The 0.01% plan payment decrease is a national average and does not account for all variables that affect plan payments. It reflects a 2.44% increase due to growth rate and a 2.45% decrease due to risk model revision and normalization factor updates. The national average plan payment decrease does not reflect a CMS FFS rebasing, which will be provided with the Final Rate Announcement or impact of Star Rating changes. CMS did provide an estimate of 3.86% for plan coding trend, although coding trend is not part of rate setting, and it is unclear how CMS developed this number.

Plans should consider how the following may vary from the national averages.

- Potential impact of FFS rate rebasing, including county-level impacts of adding 2022 FFS data and removing 2017 data from AGA calculation; FFS repricing for the most current geographic price cost indices; durable medical equipment, prosthetics, orthotics and supplies (DMEPOS) competitive bidding program changes; and Center for Medicare & Medicaid Innovation (CMMI) program impact:
  - Variances from average -0.15% Star Ratings change
  - Plan-specific coding trend
- 2025 applicable ("quartile") percentages have been updated based on 2024 FFS per-capita rates.
- CMS United States per-capita costs (USPCC)-projected cost estimates reflect the expected impact of COVID-19. This is an estimate of the average across all state and county codes in the country. The 2.44% effective growth rate is an expected blend of the total USPCC growth rate of 1.98% and the FFS growth rate of 2.57%. The FFS growth rate is a component of the total USPCC growth rate.

0.01%

plan payment decrease is a national average and does not account for all variables that affect plan payments.

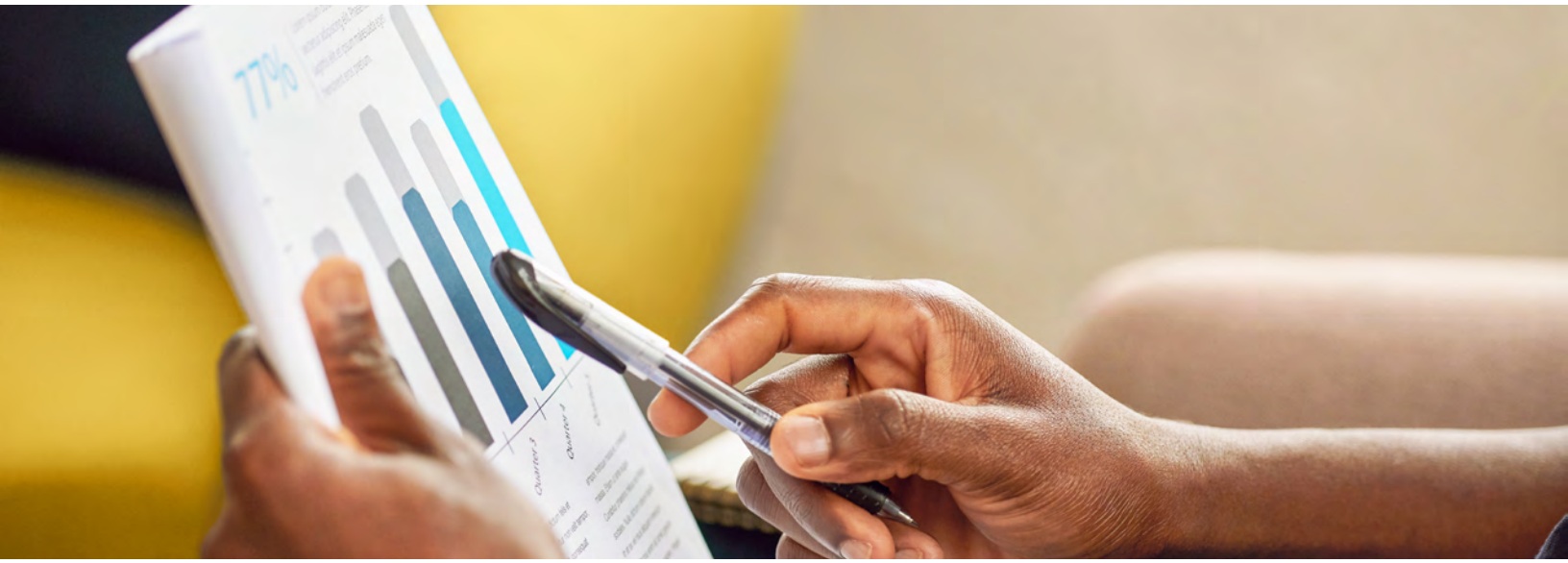
CMS is estimating the risk model revision and normalization updates to decrease average plan payments by 2.45%.

- 2025 USPCC estimates relative to 2024 Final Rate Announcement estimates:
  - Removal of indirect medical education (IME) and direct graduate medical education (DGME) costs from historical and projected expenditures will reach the second of a 3-year phase in, with 67% of the adjustment reflected. The impact of moving from a 33% to 67% adjustment is the 2025 total USPCC is 0.43% lower and 2025 FFS USPCC is 0.96% lower.
  - 2023 USPCC costs are down slightly from CMS's estimates last year. Specifically, the 2023 total USPCC is 0.5% lower and the 2023 FFS USPCC is 0.1% lower.
  - The 2024 and 2025 USPCC costs are projected to increase at a lower rate than CMS projected in 2023, which is contributing to the payment decrease.
- CMS is proposing to include the historical experience of Advanced Alternative Payment Models (APM) incentive payments disbursed in years 2019 through 2022 in the ratebook.
- CMS is proposing a blend between the 2020 CMS-HCC model frailty factors (33%) and the 2024 CMS-HCC model frailty factors (67%) for FIDE SNPs. Beginning in plan year 2025, FIDE SNP enrollment will be limited to full-benefit duals enrolled in an affiliated MCO. Non-dual and partial Medicaid frailty factors will not be applicable to the plan year 2025 population. No proposed methodology change for PACE (Program of All-inclusive Care for the Elderly) beneficiaries.
- The national average for 2025 ESRD growth rate is estimated to be 3.12%, an increase from the 2024 2.27% ESRD growth rate.

CMS noted that adjusting ESRD rates at geographic levels based on the area deprivation index (ADI) introduces concerning impacts. CMS also analyzed actual 2021 and 2022 ESRD enrollee experience, which indicates that revenues exceeded net medical expenses for most plans. Considering these analyses, CMS will continue to use statewide MA ESRD rates for 2025.

The basis of the EGWP payments rates is the average individual market bid-to-benchmark ratio by applicable percentage for the prior-year bid submission. As a result of continued increase in competition in the individual market and expansion of supplemental benefits, the individual bid-to-benchmarks declined from 2023 to 2024 by less than 0.4 percentage points, hovering around 77%.

Risk adjustment



Highlights of proposed changes

Risk scores will continue to be weighted 100% using Encounter Data System (EDS) submissions for non-PACE (Program of All-inclusive Care for the Elderly) MA plan risk score calculations.

- CMS will continue to transition from the 2020 CMS-HCC model to the 2024 CMS-HCC model, with the old model being weighted at 33% and new model weighted at 67%. While the new model adds HCCs, the underlying diagnoses codes shift from an ICD-9 basis to lower volume of ICD-10 codes.
- The MA coding pattern adjustment factor is to remain at 5.9%, consistent with 2024 (minimum statutory requirement).
- CMS is proposing a new multiple linear regression methodology for predicting normalization factors, in lieu of the existing linear slope methodology.
- The 2024 CMS-HCC model normalization factor is increasing from 1.015 to 1.045.
- The 2020 CMS-HCC model normalization factor is increasing from 1.146 to 1.153.
- The 2017 CMS-HCC model normalization factor is to decrease from 1.159 to 1.157 (applicable for PACE plans).
- Proposed changes to the RxHCC model are intended to better align with the 2025 Part D benefit design, through re-adjudication of PDE data and recalibration of model coefficients.

Star Ratings program

Highlights of proposed changes

Key theme: Driving patient-centricity and health equity by leveraging "Universal Foundation" core set of quality measures.

2025 Star Ratings update

The following updates are from the CY 2025 Medicare Advantage and Part D Proposed Rule (CMS-4205-P), and the 2025 Advance Notice Announcement.

- The deadline is June 28, 2024, for the Complaints Tracking Module (CTM) and Independent Review Entity (IRE) data review by CMS.
- Plan All-Cause Readmissions (Part C) measure returning to weight of 3.
- Medication Reconciliation Post-Discharge (Part C) stand-alone measure is at weight of 1.
- Getting Appointments and Care Quickly (Part C) – Removal of 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 CAHPS® composite.
- CMS continues to develop future Star Ratings measures based on their commitment to a building block called "Universal Foundation" consisting of a core set of quality measures aligned across all CMS quality programs. As a reminder, this Universal Foundation will consist of measures that span across 6 meaningful measure domains: Wellness and Prevention, Chronic Conditions, Behavioral Health, Seamless Care Coordination, Person-Centered Care, and Equity.

2026 Star Ratings and beyond update

Non-substantive changes to Star Ratings measures

- Diabetes Care Eye Exam (Part C) measure: Update specifications as it relates to clinical codes
- Statin Therapy for Patients with Cardiovascular Disease (Part C): Allow exclusion for patients with history of statin intolerance
- Medication Adherence for Diabetes Medication, Medication Adherence for Hypertension (RAS Antagonists), Medication Adherence for Cholesterol (Statins) (Part D), MTM Program Completion Rate MTM Program Completion Rate for Comprehensive Medication Review (CMR) (Part D), Statin Use in persons with Diabetes (SUPD): Updated data source
- Members Choosing to Leave the Plan (Part C & D): Update "move out of the service area" logic

Substantive changes to Star Rating measures*

- Breast Cancer Screening (Part C): Addition of an age group is a substantive change resulting in updated measure moving to Display page for 2 or more years; legacy measure will continue to stay in Star Ratings
- Plan Makes Timely Decisions about Appeals and Reviewing Appeals Decisions (Part C): Revising definition of timeliness, which will impact reviewing the appeals
- Care Coordination (Part C): Swapping 2 out of 6 questions with 2 new questions
- Care for Older Adults (Part C): Pain Assessment – retired by the measure steward, NCQA

Display measures:

- Initial Opioid Prescribing for Long Duration (IOP-LD) (Part D): Intent to propose to be added to Star Ratings in future
- Follow-Up After Hospitalization for Mental Illness (Part C): Measure steward, NCQA considering specifications update
- Social Need Screening and Intervention (Part C): Added to 2025 Stars display page; measure steward considering specifications update
- Adult Immunization Status (Part C): Measure steward, NCQA considering specifications update
- Polypharmacy Use of Multiple Anticholinergic Medications in Older Adults (Poly-ACH), and Polypharmacy Use of Multiple Central Nervous System Active Medications in Older Adults (Poly-CNS) (Part D): Align with measure steward, PQA specifications*

* The substantive changes are subject to rule making prior to entering star ratings

- 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): Align with measure steward, PQA specifications
- 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): Align with measure steward, PQA specifications
- Poly-CNS/Poly-ACH/COB/OHD/OMP (Part D): Align with measure steward, PQA specifications – remove anchor date and follow continuous enrollment (CE)

Retired measures:

- Antidepressant Medication Management (Part C): Measure steward, NCQA retiring the measure
- Use of Opioids from Multiple Providers in Persons Without Cancer (OMP) (Part D): Measure steward, PQA considering retiring the measure

Potential new measure concepts and methodological enhancements

CMS is requesting stakeholder input on the proposed concepts to further engage in the rulemaking process. The rulemaking will formally introduce these concepts in the Star Ratings program.

- Health Outcomes Survey (Part C): New measures and method is tested. Content will come from 3 key items: Patient-Reported Outcomes Measurement Information System (PROMIS) Physical Function Items; Generalized Anxiety Disorder 2 (GAD-2) Items; and Health-Related Social Needs (HRSN) Items
- Blood Pressure Control for Patients with Hypertension (Part C): Measure steward, NCQA exploring concept
- Breast Cancer Screening Follow-Up (Part C): Measure steward, NCQA exploring concept
- Social Connection Screening and Intervention (Part C): Measure steward, NCQA developing new measure
- Chronic Pain Assessment and Follow-Up (Part C): Measure steward, NCQA developing new measure
- Tobacco Use Screening and Cessation and Lung Cancer Screening and Follow-Up (Part C): Measure steward, NCQA developing 2 new measures

Star Ratings program (continued)

- Functional Status Assessment Follow-Up (Part C): Measure steward, NCQA developing new ECDS measure
- Cross-Cutting: Sexual Orientation and Gender Identity for HEDIS® Measures (Part C): To be inclusive and gender-affirming while aligning with the measure intent
- Cross-Cutting: Identifying Chronic Conditions in HEDIS Measures (Part C): Simplifying identification of chronic conditions
- Medicare Plan Finder Drug Pricing Measure (Part D): CMS developing new measure and retiring MPF - Stability display measure

Part D program changes

Highlights of proposed changes

- Part D benefit parameter increases consistent with changes in the annual percentage increase (API) in Part D expenditures are as follows:
  - 8.58% API for 2025 reflects a 5.46% for 2024 trend and multiplicative update of 2.96% adjustment for prior periods
  - Deductible is increasing from $545 to $590
  - Initial coverage limit will not exist in 2025 (was $5,030 in 2024), as the coverage gap phase will be going away
  - The out-of-pocket threshold is decreasing from $8,000 to $2,000
- The Medicare Prescription Payment Plan (M3P) will allow enrollees to make coinsurance payments in the form of equal monthly installments over the remaining portion of the plan year

Highlights of proposed changes on benefit designs

In August 2022, President Biden signed into law the Inflation Reduction Act (IRA) of 2022, which includes provisions aiming to lower health care and energy costs. The law includes several amendments and additions to the standard Part D drug benefit defined in the Social Security Act. The Part D benefit-related IRA updates that will be in place for CY 2025 and that are described in the Advance Notice include:

Part D program changes (continued)

1. **Elimination of coverage gap phase in CY 2025**. Starting 2025, the Part D benefit will only include 3 benefit phases (deductible, initial coverage limit and catastrophic).
2. **True Out-of-Pocket Threshold (TrOOP) of $2,000.** In CY 2025, beneficiaries will have a Part D TrOOP of $2,000. This is down considerably from the $8,000 threshold in 2024. TrOOP-eligible expenses will include member liability, supplemental benefit coverage and insulin cost sharing.
3. **Changes to the manufacturer discount program.** With the coverage gap phase going away in CY 2025, the coverage gap discount program will no longer exist. Instead, for brand drugs, the new manufacturer discount program will cover 10% of the cost in the initial coverage limit phase and 20% of the cost in the catastrophic phase.

Other announcements

Highlights of 2025 Medicare Advantage and Part D Proposed Rule

On November 6, 2023, CMS released the 2025 Medicare Advantage and Part D Proposed Rule (CMS-4205-P). CMS is proposing several changes that could have a significant impact on health plan benefits, member premiums and health plan operations. The comment period for the proposed rule ended January 5, 2024.

There is no indication when a Final Rule will be issued by CMS. There is no indication that the rule will be finalized to support health plans in their CY 2025 bid development. For example, the CY 2022 Final Rule for Medicare Advantage and Part D was issued on June 2, 2021. Stakeholders should work closely with CMS for guidance on how any potential impact on CY 2023 pricing should be included in the bid pricing process that is due on June 3, 2024.

New guardrails for plan compensation to agents and brokers

1. CMS is proposing to redefine “compensation” to a clear, fixed amount, versus the variability in payments the exists today. The reason for the proposal is to ensure that individuals are enrolled in a Medicare Advantage plan that best suits their needs.
2. Improving access to behavioral health care providers: Through separate rulemaking, CMS has expanded the volume of providers that will be eligible to enroll in Medicare and bill for behavioral health services starting January 1, 2024. CMS has also proposed that these providers receive a 10% credit if certain telehealth requirements are met. The eligibility expansion will impact an estimated 400,000 marriage and family therapists (MFTs) and mental health counselors (MHCs), and expand access for Medicare Advantage enrollees.

Other announcements (continued)

3. Dual Eligible Special Needs Plan (D-SNP) marketplace impacts: CMS has a few proposals that would impact D-SNPs. One proposal is to create a once-per-month special enrollment period (SEP) for dually eligible individuals to enroll in a stand-alone prescription drug plan or integrated care plan, with the goal being increased enrollee access to integrated materials. Another proposal is to lower the D-SNP look-alike threshold from 80% to 70% in 2025, and to 60% in 2026. Finally, for D-SNP preferred provider organizations (PPOs), there is a proposal to limit out-of-network cost sharing, starting in 2026.
4. New standards in offering supplemental benefits: CMS is proposing a few updates to the supplemental benefit requirements. A couple updates pertain specifically to special supplemental benefits offered to the chronically ill (SSBCI), including a requirement that bids demonstrate a reasonable expectation of improved health for enrollees and clarification of benefit availability within marketing materials. Another proposal is that Medicare Advantage plans need to engage in minimum outreach efforts to enrollees for all supplemental benefits offered, including a "Mid-Year Enrollee Notification of Unused Supplemental Benefits."
5. Standardize the Medicare Advantage Plan Risk Adjustment Data Validation (RADV) Appeals Process: CMS is proposal several updates, to address operational constraints that exist in the RADV appeals process.

4 things to consider for bid preparation

Financial impact may vary from plan to plan based on a combination of:

- Benchmark changes
- Risk adjustment changes
- Cost sharing and benefit design
- Star Ratings
- Service-area mix
- Contracting arrangements

Understand impact of Part D program changes, including M3P and RxHCC model changes

Continue to address health disparities of complex populations with a holistic approach toward health equity and inclusivity

Review impact of CMS-HCC model changes

Prepare for changes to the Value-Based Insurance Design (VBID) Model requirements

Optum is here to help

More than ever, Medicare Advantage plans must continue to execute effectively. They need to address quality, risk adjustment and cost of care if they are to produce achievable, competitive bids and provide products that reach stated goals for benefits, member premiums and margins. Integrating initiatives across each of these functions may improve results, improve the member and provider experience, and reduce program costs.

Optum is unique in its alignment and delivery of the critical combination of actuarial, care management and operational consulting expertise. In an environment where there are an increasing number of issues to address, we have helped our clients achieve the balanced approach they need to manage the challenges of the Medicare Advantage market.

Optum is unique in its combination of:

- Actuarial
- Care management
- Operations
- Technology

Actuarial services and performance reporting: We have the experience and tools to assist in developing strategic bid pricing to help align with a plan sponsor's operational and strategic goals. We offer both Parts C and D reporting tools to help plan sponsors monitor their performance during the plan year. This includes leveraging social determinants of health within analytics to understand gaps or barriers in care and help inform operational activities to advance health equity.

Risk score accuracy: We offer clinical and operational insight and delivery support to improve the accuracy and completeness of risk scores, combined with the analytics to illustrate the revenue impacts and critical path for such initiatives.

Star Ratings program and performance management: We offer projections, assessments and targeted solutions such as Part D performance improvement, advanced analytics and other critical components to improve Star Ratings performance. Optum also offers consulting and solutions for member-rereported "experience" measures, including CAHPS and Health Outcomes Survey (HOS) measure sets.

Population health management: We have deep experience in care management and network management to minimize risk.

Enabling risk-based reimbursement: We bring hands-on experience in creating transformational provider risk-sharing arrangements.

Meet our experts

Gregory J. Backus, ASA, MAAA

Senior Director, Optum Government Programs Actuarial Services

Greg is an accomplished actuary with over 20 years of experience working at several health plans. He has held multiple actuarial leadership roles in payer organizations with both Medicare and Medicaid product lines.

Alex Balmes

Vice President, Optum Government Programs Actuarial Services

Alex has 20 years of experience in health care, including 16 years providing actuarial services within Optum Advisory. His current focus is on Medicare Advantage, Medicaid and the ACA lines of business. His experience includes MA and Part D bid development, reserving, provider contracting, RA valuation, M&A management, actuarial recruiting and analytical systems development.

Rose A. Bernards, MBA

Practice Lead, Risk Adjustment, Optum Advisory

Rose brings over 25 years of health care experience to her role as part of Optum Advisory. Rose's career spans a combination of ambulatory clinic, hospital, insurance and vendor roles, providing unique, integrated perspectives across the health care landscape. She currently helps support both payers and providers seeking to improve accurate and complete documentation and coding for their risk-adjusted contracts across Medicare, Medicaid and commercial lines of business.

Tejaswita Karve, PhD

Practice Lead, Star Ratings, Optum Advisory

Tejaswita's expertise includes leveraging population health management strategies to maximize performance on quality ratings programs, specifically on the Medicare Star Ratings program. Tejaswita has over a decade of experience across several Fortune 100 organizations and renowned integrated delivery and finance systems. She has led the lifecycle of Star Ratings program from developing data-driven strategies, to building reporting and analytics capabilities as well as driving execution efforts. She is experienced in promoting advocacy positions with the state and federal agencies (CMS, Defense Health Agency) in support of whole-person care models and integrating social determinants of health in care delivery to help achieve better quality outcomes while delivering a seamless member experience.

Let’s talk about how we can help you assess and address 2025 proposed regulatory changes.

optum.com/contact-us

This document includes guidelines within our definition of the 2024 CMS Rate Announcement and other regulatory changes. All information contained herein is provided solely as commentary and should not be misunderstood as constituting legal or compliance advice. Plans should consult their own legal and/or compliance advisors as to recommended next steps.

Sources

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