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Introductory note

1) For questions regarding bid instructions or completing the BPTs: actuarial-bids@cms.hhs.gov
For COVID-19 policy and benefit related questions: https://ma-covid19-policybenefits.lmi.org/covid19mailbox
For Part C policy-related payment questions: PartCpaymentpolicy@cms.hhs.gov
For Part C policy-related questions (including OOPC/TBC policy): https://mabenefitsmailbox.lmi.org/
For Part D policy-related questions: partdpolicy@cms.hhs.gov
For Part D benefit-related questions (including OOPC/TBC policy): partdbenefits@cms.hhs.gov
For questions related to risk score models and released data: riskadjustmentpolicy@cms.hhs.gov
For questions related to the Encounter Data Processing System: riskadjustmentoperations@cms.hhs.gov
For technical questions regarding the OOPC model: OOPC@cms.hhs.gov
For questions related to the Health Plan Management System (HPMS): HPMS@cms.hhs.gov
For questions related to the Medicare Advantage Prescription Drug system (MARx): MARXSSNRI@cms.hhs.gov
For questions related to the Medicare Part D Coordination of Benefits: PartD_COB@cms.hhs.gov

#	Topic	Date E-Mail Sent	E-mail Subject	E-Mail Body Text	CMS Response
1	Part D	N/A	N/A	Should members that join the plan mid-year rely on reported CGDP from the PDEs or an estimated CGDP number when determining if they have reached the catastrophic phase? We will not have access to reported CGDP from PDEs from the plan the member came from. Is the CGDP approximation [(minimum(gross total drug cost, 11,206.28) − 4,660) x (92.13% x (94.969% − 25%))] intended to calculate the member's full CGDP amount, or is it intended to be used to calculate some amount of CGDP for only the Plan-to-Plan transaction (and, depending on the answer to #1, the member's prior spend), which would be added to reported CGDP?	The CGDP approximation referenced in the question was presented on the November 2023 User Group call as a suggestion for how to estimate the CGDP. Plan sponsors should use whatever method they believe produces the most reasonable result and provide support for that methodology.
2	Part D	N/A	N/A	Should the approximated CGDP amount be reported anywhere on WS1 or is it purely to be used for determining if a member has reached the catastrophic phase and all reported amounts should be based on actuals from the PDEs	The base period CGDP amount should only be entered in cell M60 on worksheet 1. Plan sponsors should not enter Gap Discount amounts into column J, Average Cost Sharing per Member on WS1. Gap Discount amounts will need to be a component of base period reconciliation to financials.
3	Part D	N/A	N/A	For WS1, the November UGC agenda said "For Plan-to-Plan transaction reporting on worksheet 1, please estimate the gap discount according to the values provided in the 2023 Rate Announcement". The formulas provided only works for Non-LIS members. However, there is no gap discount for LIS members and the LICS in ICL and GAP intervals also count towards the TrOOP in the base year data. How should plans allocate the OOP cost for LIS members to ICL from Catastrophic phase?	Plan sponsors may allocate the OOP using the estimated allowed cost at catastrophic for low income beneficiaries published in the contract year 2023 Rate Announcement. We recognize that this will create significant differences between the base and projection year distributions. Similar to the response above, plan sponsors should use a method that produces a reasonable result and provide support for that methodology.
4	Part D	N/A	N/A	With respect to the new IRA Part D Drug Experience section on WS1, should these amounts include or exclude PDEs with Part D as secondary?	New Section VI on Worksheet 1 for IRA Part D Drug Experience should include Part D as secondary.
5	Part D	N/A	N/A	Where should we put the subsidy amount for CY2023 for insulins and vaccines?	2023 IRA subsidy amount (IRASA) for insulins and vaccines should be included in member cost sharing.
6	Part D	N/A	N/A	How should utilization and costs be reported on Worksheet 6 for a member with utilization and costs that exceed the catastrophic under the alternative benefit, but do not exceed the catastrophic under the DS benefit?	The utilization and costs for this member should be split between lines 1–10 and line 39 on Worksheet 6. The utilization and costs for this member that do not exceed the catastrophic should be reported in line 1–10, while the utilization and costs for this member that exceed the catastrophic should be reported in line 39.
7	USPCC	N/A	N/A	[Paraphrased] What is the CMS 2024 and 2025 PMPM estimate for Leqembi?	In the 2025 Advance Notice non-ESRD FFS USPCC tabulations, the estimated Leqembi spending is $1.67 PMPM for CY 2024 and $4.67 PMPM for CY 2025.

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#	Topic	Date E-Mail Sent	E-mail Subject	E-Mail Body Text	CMS Response
8	USPCC	02/01/2024 21:01	Advance Notice Question	We are working on our comments on the Advance Notice and it would be helpful if we could understand the impact of the restatements in the FFS USPCCs in Table I-5. Specifically, can you provide the restatements by year separately for each of the following: 1) Impact of the Year 2 Phase-in Removing MA-related IME/DGME 2) Remedy for the 340B-Acquired Drug Payment Policy for Years 2018–2022 3) Other (If there are items within this category that are large enough to identify separately, please do so)	As reflected in table 1, there are three significant adjustments in the 2025 Advance Notice non-ESRD FFS USPCCs compared to the 2024 Rate Announcement: a. Removal of 33 percent MA medical education phase-in for years prior to CY 2024. The pre-2024 reduction in the contract year 2024 Rate Announcement USPCCs was incorrect but had no impact on the 2024 ratebook growth rates. b. Impact of 340B acquired drug remedy for CY 2018–CY 2021. No adjustment was required for 2022 since the CY 2022 340B claims were reprocessed during calendar years 2022 and 2023. c. Impact of increase of MA medical education FFS phase-in from 33 percent in CY 2024 to 67 percent in CY 2025. Please note that the first two of these items, MA medical education correction and historical 340B remedy, have no impact on the 2025 Advance Notice growth rates.
9	USPCC	N/A	N/A	Please provide the impact of the remedy for the 340B-Acquired Drug Payment Policy for Years 2018–2022 and 2026.	The impact of the 340B-Acquired Drug remedy on the non-ESRD Part B FFS USPCCs is 2018: 1.07%; 2019: 1.16%, 2020: 1.30%, 2021: 1.23%. The CY 2022 remedy was addressed through reprocessing of the claims and the estimated impact is about 1.20%–1.30% on the Part B non-ESRD FFS USPCC. Consistent with CMS' regulation, CMS-1793-F, to budget neutralize the remedy there will be a 0.5-percent reduction in payments for non-drug outpatient hospital services beginning in 2026. This reduction is expected to reduce the non-ESRD Part B USPCC by about 0.11% in 2026.
10	USPCC	N/A	N/A	It is difficult to understand the baseline Part A USPCC trends given the tables in the 2025 Advance Notice include the effects of the MA medical education phase-in. Can you provide additional information on the Part A FFS trends excluding the impacts of MA medical education?	Please refer to table 2 which illustrates the 2025 Advance Notice FFS USPCCs as published and excluding the phase-in of the MA medical education. The annual impacts of the MA medical education adjustment on the non-ESRD FFS USPCCs are 2024: 33% phase-in of MA medical education and −$9.41 impact; 2025: 67% phase-in of MA medical education and −$20.90 impact; and 2026: 100% phase-in of MA medical education and −$33.80 impact. Also, the illustration excluding the impact of the MA medical education phase in shows that the Part A annual trends for 2022–2026 are relatively consistent with a low of 3.96% in 2025 and a high of 4.86% in 2024.
11	USPCC	N/A	N/A	Based on the published USPCCs, the implied trends for 2024 decreased from 4.5% to 3.3% and 2025 implied trends decreased from 4.1% to 3.8%. What is driving the reduction in forward looking trends from the 2024 Final Notice to the 2025 Advance Notice? We are surprised to see this reduction in forward looking costs especially given public statements from MAOs regarding continued elevated utilization during Q3/Q4 2023.	Please refer to table 3, which has three presentations of USPCCs: (i) Published in 2024 Rate Announcement (RA), (ii) 2024 Rate Announcement with corrected MA medical education phase out for years 2021-2023, and (iii) 2025 Advance Notice (AN). The table shows that the 2024 and 2025 Parts A + B trends for the restated CY 2024 RA values are within 40 basis points for both years. Following are some of the factors contributing to the changes in the trend rates from restated CY 2024 RA to the CY 2025 AN. The 2023 Part A trend decreased from 7.93% in the restated CY 2024 RA to 4.00% in the CY 2025 AN baseline. The main driver of this difference is lower actual 2023 spending for inpatient and home health than was projected in the CY 2024 RA. The 2024 trend for Part A is 1.75 percent higher in the CY 2025 AN versus CY 2024 restated RA baseline. This increase for CY 2025 AN is largely due to assumptions for projected utilization more that is more consistent with pre-pandemic levels. For inpatient there is an additional 2024 trend of 1.9% in 2024. And for home health, we expect an increase in spending due return to normal from the current labor shortage. This additional home health trend is 2.4% per year for 2024–2026. The 2023 Part B trend decreased by 0.24% from the CY 2024 RA to CY 2025 AN baseline. This change is due to a combination of lower actual outpatient spending for 2023 than was projected in the CY 2024 AN and higher spending for DME and Part B drugs. The 2024 Part B trend is down 1.86% in the CY 2025 AN primarily due to a new assumption that outpatient utilization will not return to pre-pandemic levels, reduction in DME spending, and reduction in other carrier services due to elimination of spending for COVID-19 tests once the Public Health Emergency ended on May 11, 2023.
12	USPCC	N/A	N/A	What did OACT assume for the cost and utilization assumptions for COVID-19 vaccines in each of the 2024 and 2025 projection years?	FFS spending for COVID-19 vaccines was $1.85 PMPM in 2022 and $3.85 in 2023. The CY 2025 Advance Notice USPCC baseline includes 2023 COVID-19 vaccine experience through the third quarter, which is then trended forward with category-level assumptions for price, utilization, and residual.

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13	USPCC	N/A	N/A	Can CMS please provide the estimates of excess morbidity on aggregate per capita spending used to support the 2025 Advance Notice?	The excess morbidity factors supporting the CY 2025 Advance Notice baseline are the same as that used in the development of the CY 2024 Rate Announcement baseline, and the CY 2023 Medicare Trustees' Report baseline. These factors are reported on page 39 of the CY 2024 Rate Announcement.
14	USPCC	N/A	N/A	Can CMS please explain how the excess morbidity estimates were applied in the development of the FFS USPCCs?	The annual change in morbidity factors is included as an additional trend factor in the Medicare fee-for-service baseline. For example, the aggregate morbidity factor is −4.4 percent for 2023 and −3.9 percent for 2025. Given that 2023 is the base period, the change in morbidity assumptions from 2023 to 2025 resulted in approximately +0.5 percent increase in FFS trend in the CY 2025 Advance Notice baseline.
15	USPCC	N/A	N/A	Please provide information on what is driving the restatements in ESRD USPCCs shown in the CY 2025 Advance Notice Table I-6 for 2022 to 2026?	The lower ESRD USPCCs in the CY 2025 Advance Notice are due primarily to lower actual experience for 2023 than reflected in the CY 2024 Rate Announcement, and the removal of the assumption that dialysis utilization will return to pre-2020 levels.

Table 1: Impact of 2025 AN adjustments on A+B non-ESRD FFS USPCCs

Item	2018	2019	2020	2021	2022	2023	2024	2025
a. Remove 33% MA med. ed. pre-2024	0.40%	0.44%	0.54%	0.60%	0.67%	0.77%	0.00%	0.00%
b. 340B acquired drug remedy	0.60%	0.66%	0.73%	0.72%	0.72%	0.00%	0.00%	0.00%
c. Transition from 33% to 67% med. ed.	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	−0.93%

Table 2: Non-ESRD FFS USPCCs

	USPCCs AN 2025			USPCC w/o MA med ed phase-in		
	Part A	Part B	A + B	Part A	Part B	A + B
PMPM						
2021	$390.91	$557.21	$948.12	$390.91	$557.21	$948.12
2022	$407.54	$578.89	$986.43	$407.54	$578.89	$986.43
2023	$423.83	$633.29	$1,057.12	$423.83	$633.29	$1,057.12
2024	$435.00	$657.21	$1,092.21	$444.41	$657.21	$1,101.62
2025	$441.10	$692.35	$1,133.45	$462.00	$692.35	$1,154.35
2026	$450.27	$735.17	$1,185.44	$484.07	$735.17	$1,219.24
Annual trend						
'22/'21	4.25%	3.89%	4.04%	4.25%	3.89%	4.04%
'23/'22	4.00%	9.40%	7.17%	4.00%	9.40%	7.17%
'24/'23	2.64%	3.78%	3.32%	4.86%	3.78%	4.21%
'25/'24	1.40%	5.35%	3.78%	3.96%	5.35%	4.79%
'26/'25	2.08%	6.18%	4.59%	4.78%	6.18%	5.62%

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Table 3: Non-ESRD FFS USPCCs

	RA 2024 (published)			RA 2024 (corrected MA med ed 2021–2023)			AN 2025		
	Part A	Part B	A + B	Part A	Part B	A + B	Part A	Part B	A + B
PMPM									
2021	$384.05	$550.73	$934.78	$389.69	$550.73	$940.42	$390.91	$557.21	$948.12
2022	$398.10	$573.64	$971.74	$404.72	$573.64	$978.36	$407.54	$578.89	$986.43
2023	$428.63	$629.07	$1,057.70	$436.83	$629.07	$1,065.90	$423.83	$633.29	$1,057.12
2024	$440.70	$664.40	$1,105.10	$440.70	$664.40	$1,105.10	$435.00	$657.21	$1,092.21
2025	$451.09	$698.89	$1,149.98	$451.09	$698.89	$1,149.98	$441.10	$692.35	$1,133.45
2026	$459.88	$739.42	$1,199.30	$459.88	$739.42	$1,199.30	$450.27	$735.17	$1,185.44
Annual trend									
’22/’21	3.66%	4.16%	3.95%	3.86%	4.16%	4.03%	4.25%	3.89%	4.04%
’23/’22	7.67%	9.66%	8.85%	7.93%	9.66%	8.95%	4.00%	9.40%	7.17%
’24/’23	2.82%	5.62%	4.48%	0.89%	5.62%	3.68%	2.64%	3.78%	3.32%
’25/’24	2.36%	5.19%	4.06%	2.36%	5.19%	4.06%	1.40%	5.35%	3.78%
’26/’25	1.95%	5.80%	4.29%	1.95%	5.80%	4.29%	2.08%	6.18%	4.59%