Calculation of Medicare Fee-for-Service Actuarial Equivalent Cost Sharing for Contract Year 2025

1. Statutory / Regulatory Basis
    a. SSA 1854(a)(6)(A) INFORMATION TO BE SUBMITTED: For an MA plan (other than an MSA plan) for a plan year beginning on or after January 1, 2006, the information described in this subparagraph is as follows:
        (i) The monthly aggregate bid amount for the provision of all items and services under the plan, which amount shall be based on average revenue requirements (as used for purposes of section 1302(8) of the Public Health Service Act) in the payment area for an enrollee with a national average risk profile for the factors described in section 1853(a)(1)(C) (as specified by the Secretary).
        (ii) The proportions of such bid amount that are attributable to—
        (I) the provision of benefits under the original Medicare fee-for-service program option (as defined in section 1852(a)(1)(B)), including, for plan year 2020 and subsequent plan years, the provision of additional telehealth benefits as described in section 1852(m);
        (II) the provision of basic prescription drug coverage; and
        (III) the provision of supplemental health care benefits.
    b. SSA 1852(a)(1)(B) (i) In general.—For purposes of this part, the term "benefits under the original Medicare fee-for-service program option" means, subject to subsection (m) those items and services (other than hospice care or coverage for organ acquisitions for kidney transplants, including as covered under section 1881(d)) for which benefits are available under parts A and B to individuals entitled to benefits under part A and enrolled under part B, with cost-sharing for those services as required under parts A and B or, subject to clause (iii), an actuarially equivalent level cost-sharing as determined in this part.
    c. In the Preamble to Final rules (January 28, 2005), there were several alternative approaches to defining the actuarially equivalent amount of cost sharing for the basic A/B bid amount:
        (i) localized uniform dollar amount;
        (ii) plan-specific approach; and
        (iii) proportional approach.
    d. Regulation Text, CFR 42, Section 422.254(b)(4) The bid amount is for plan payments only but must be based on plan assumptions about the amount of revenue required from enrollee cost-sharing. The estimate of plan cost-sharing for the unadjusted MA statutory non-drug monthly bid amount for coverage of basic benefits as defined in § 422.100(c)(1) must reflect the requirement that the level of cost sharing MA plans charge to enrollees must be actuarially equivalent to the level of cost sharing (deductible, copayments, or coinsurance) charged to beneficiaries under the original Medicare fee-for-service program option. The actuarially equivalent level of cost sharing reflected in a regional plan's unadjusted MA statutory non-drug monthly bid amount does not include cost sharing for out-of-network Medicare benefits, as described at § 422.101(d).

2. The methodology implemented by OACT is the proportional approach, based on Medicare fee-for-service (FFS) cost sharing proportions (that is, the proportion of enrollee cost sharing, excluding balance billing, to total allowed cost). These proportions were developed for the following service categories and service areas:

a. inpatient for local areas;
b. skilled nursing facility for local areas;
c. home health, covered under both Part A and Part B – (the proportion is 0 percent for all areas since there is no cost sharing for home health in Medicare FFS); and
d. Part B services other than home health, a national proportion.
    (i) Note that the Part B cost sharing proportion was determined at the national level.

3. Primary data:
    a. Medicare FFS reimbursements tabulated from the 2022 100% National Claims History (NCH) files by state and county, excluding ESRD beneficiaries. The following adjustments were made to the data:
        (i) Included payments for disproportionate share hospitals (DSH);
        (ii) Excluded indirect medical education (IME); and
        (iii) Excluded portion of pass-through (estimated to be 90%) that pertains to direct graduate medical education (DGME).
    b. 2022 county-level HCC risk scores developed under the blended CMS-HCC model to be implemented for 2025 MA bidding and payment
    c. 2022 Part A and Part B county-level enrollments. This file is consistent with the county-level enrollment published on the CMS website.
    d. Core based statistical area (CBSA) for each county, defined by the Office of Management and Budget. These are the definitions used in the development of the final rule for the FY 2024 Inpatient Prospective Payment System (IPPS).
    e. Estimate of PMPM incurred allowed charges and cost sharing from latest CMS estimates (consistent with the baseline supporting the 2025 rate book development). These PMPM estimates exclude indirect medical education (IME) and direct graduate medical (GME).

4. Consolidate county-level NCH claims data, FFS enrollment, and risk scores.
    a. A listing of unique county codes in NCH data was developed.
    b. Using the listing of the unique county codes, the following data was imported for each county code
        (i) County name
        (ii) CBSA code and CBSA name
        (iii) 2022 FFS risk score based on 2025 CMS-HCC payment model and standardized to 1.0 on a national level
        (iv) 2022 aged & disabled FFS enrollment. Enrollment for Puerto Rico beneficiaries limited to those with coverage for Medicare Part A and Part B.
        (v) 2022 NCH reimbursement and cost sharing for inpatient, SNF, and Part B excluding home health. Reimbursements for Puerto Rico beneficiaries limited to those with coverage for Medicare Part A and Part B.
        (vi) Net inpatient reimbursements were calculated as payments (which include IME) plus 10% of pass through minus IME.

5. Develop county-level CBSA code and set Final CBSA code and name.
    a. Merge initial CBSA code and name, risk score, enrollment, payments, and cost sharing.

   b. The final CBSA code was determined as follows:
      (i) If Part A enrollment in initial CBSA >= 49,999.5 then final CBSA code equals the initial CBSA code; else
      (ii) Final CBSA code equals state code.
   c. Aggregated for each final CBSA code, the standardized reimbursement and cost sharing values calculated as the unadjusted value divided by risk score.

6. Determine growth factors for base year 2022 to 2025.
   a. Growth factors by service category are determined by using the 2022 reimbursements and cost sharing by service category and the total standardized reimbursements along with 2025 reimbursements and cost sharing by service category from CMS' latest estimate.
   b. The 2025 reimbursements and cost sharing from CMS' latest estimate are completed for expected run-out whereas the 2022 reimbursements and cost sharing derived from the NCH files are not. Also, the 2025 reimbursements and cost sharing from CMS' latest estimate contain additional expenditures such as bad debt and HPSA bonuses. Thus, the growth factors calculated incorporate trend, completion, and additional expenditures.

7. Develop CBSA-level actuarial equivalent factors for 2025.
   a. Count of FFS beneficiaries and aggregate reimbursement and cost sharing values for each CBSA are calculated.
   b. PMPM standardized values for 2022 calculated as the aggregate values divided by FFS enrollment divided by 12.
   c. PMPM standardized values for 2025 calculated as the standardized values for 2022 times (1 + '25/'22 growth factor).

8. Calculate 2025 claims non-DE# vs. total.
   a. Determine relationship of 2022 allowed cost, and cost sharing for non- DE# beneficiaries compared to all Medicare beneficiaries.
   b. Data source: 2022 national claims history as reflected in the Medicare integrated data repository (IDR).
   c. 2022 PMPM values are summarized for all Medicare beneficiaries and non-DE# populations
   d. Non-DE# projected forward to 2025 using growth factors for all Medicare beneficiaries.

9. Calculate 2025 standardized values for non-DE# beneficiaries
   a. 2025 PMPM by CBSA allowed cost and cost sharing for non-DE# beneficiaries are calculated as the product of each CBSA value for all Medicare beneficiaries and the ratio of CY 2025 PMPM allowed cost, and cost sharing for non-DE# beneficiaries.
   b. The cost sharing percentages by CBSA are calculated as the relevant cost sharing PMPM divided by the allowed cost PMPM.

10. Input CBSA-level cost sharing factors and allowed costs for non-DE# beneficiaries into BPT rates sheet.
    a. Due to absence of credible area-specific data, national average factors are used for counties in Virgin Islands, American Samoa, Guam, and the Northern Mariana Islands.