2025 Part D Risk Adjustment Model Update User Group

9/14/2023 | 2:00 – 3:00 pm ET

Access the Slide Deck

CSSCOperations.com[1]

- Training/User Group (left hand side of the page)
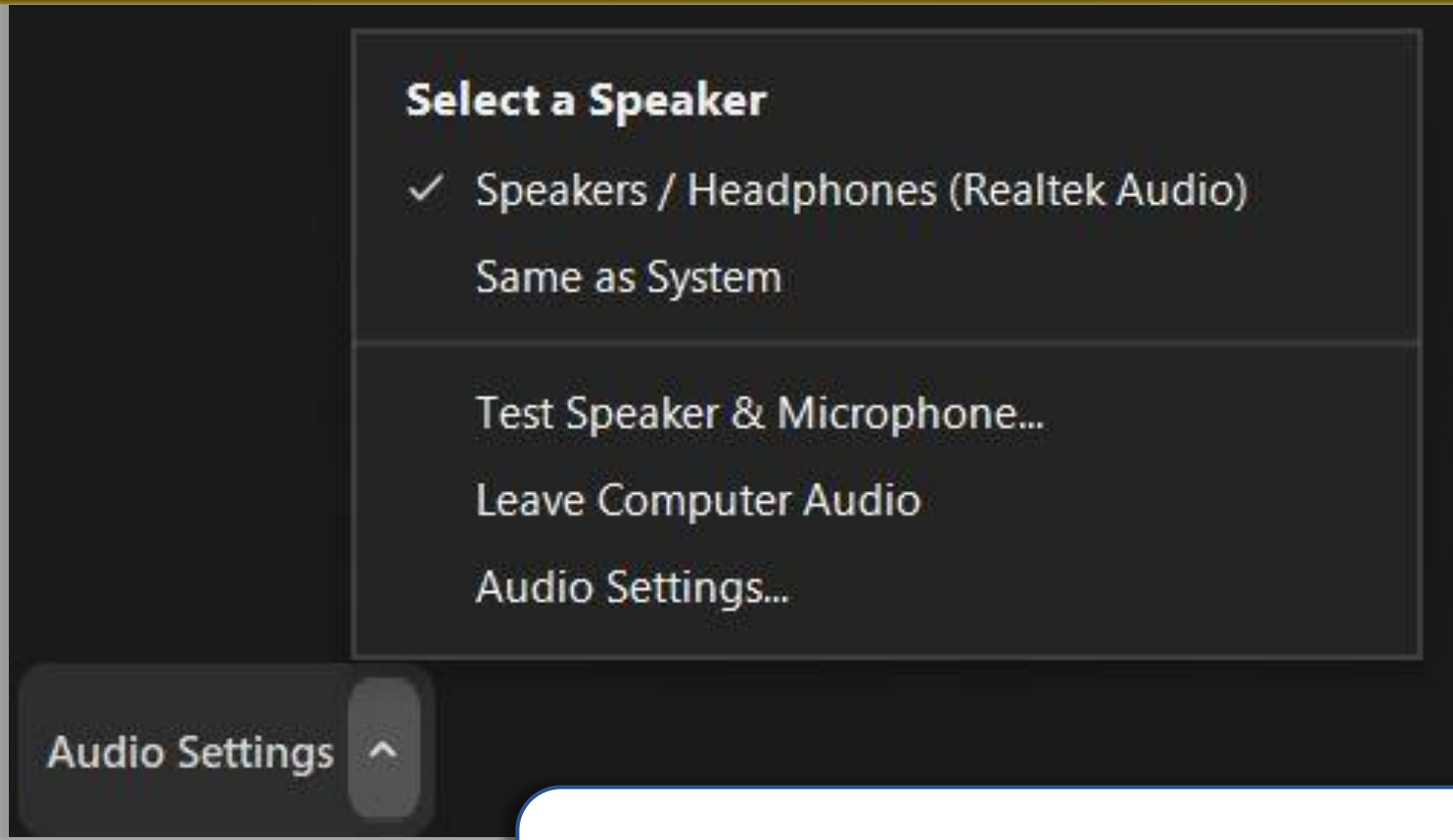- Scroll down to view all User Group slide presentations

CMS.gov[2]

- Medicare dropdown
- Payment menu
- Medicare Advantage Rates & Statistics
- Risk Adjustment (left-hand side of the page)
- Other Model Related Documents

[1] https://www.csscoperations.com/internet/csscw3.nsf/DID/R3AKWINLZ2

[2] https://www.cms.gov/medicare/health-plans/medicareadvtgspecratestats/risk-adjustors-items/riskothermodel-related

Joining Audio

Select a Speaker

✓ Speakers / Headphones (Realtek Audio)

Same as System

Test Speaker & Microphone...

Leave Computer Audio

Audio Settings...

Audio Settings ⌃

Throughout the User Group, your microphone will be muted, and you not be able to unmute yourself.
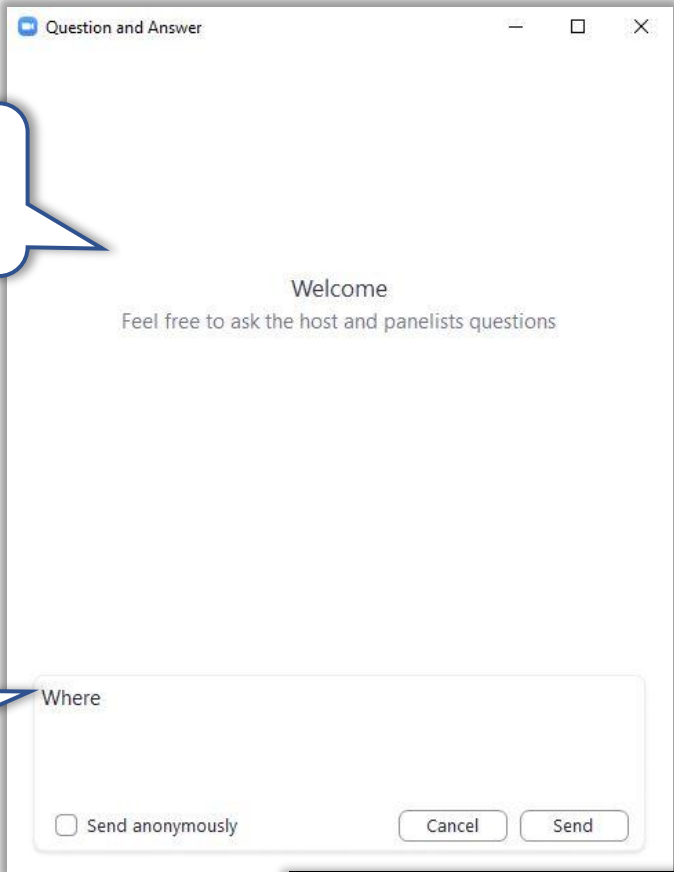
Unmute   Chat   Q&A

When you enter the User Group from the Waiting Room, you can test your audio using the Audio Settings button in the bottom right of your screen.
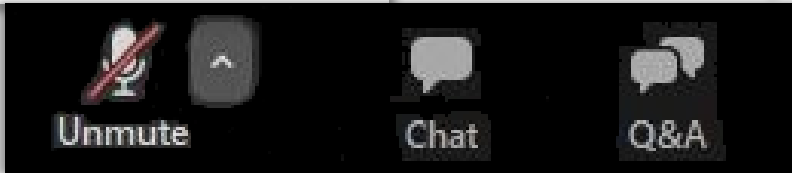
Ask Questions in the Q&A Box

Your questions and any answered questions will appear here.

Type your question in the Q&A box and press the Send button.

Select the Q&A button on the toolbar at the bottom of your screen to open the Q&A box.

Questions

Operational Questions

Encounter Data Communications/Inquiry Inbox:

RiskAdjustmentOperations@cms.hhs.gov

Policy Questions

Risk Adjustment Policy Communications/Inquiry Inbox:

RiskAdjustmentPolicy@cms.hhs.gov

Objectives

CMS is sharing the following information:

1 Notify stakeholders that CMS is updating the Part D (RxHCC) risk adjustment model to reflect statutory changes so that the model is aligned with the IRA benefit structure

2 Provide a refresher on the RxHCC risk adjustment model

3 Provide information about the changes being made to the model in response to the IRA

4 Share early estimates of the impact these model changes are expected to have on predicted plan liability for gross drug costs

Purpose: CMS is sharing this preliminary information because statutory changes to the Part D benefit for 2025 in the Inflation Reduction Act (IRA) result in significant changes to the RxHCC model.

Agenda

1 Part D Payment, Risk Adjustment in Part D and the RxHCC Model

2 RxHCC Model Development

3 Inflation Reduction Act (IRA) Updates to Part D Benefit for CY2025

4 Early Predicted Plan Liability Results for CY 2025 Model

5 Question and Answer Session

6 Resources and Appendix

Part D Payment, Risk Adjustment and the RxHCC Model

Part D Payment System

- Medicare Part D payments are based on bids that Part D plan sponsors submit to CMS.

- Beneficiaries pay a portion of plan bids through beneficiary premiums, and the government pays the rest through the direct subsidy.

- These bid-based payments are risk adjusted using a risk adjustment model developed specifically for Part D.

- Part D plans receive separate payments from the government to cover certain expenses for beneficiaries with high drug costs (reinsurance) and to reduce most out-of-pocket costs for low-income beneficiaries. Part D plans also receive statutorily-mandated discounts from pharmaceutical manufacturers for brand drugs. These payments from the government and manufacturers are not risk adjusted.

Part D Risk Adjustment

- The purpose of the Part D risk adjustment model is to ensure payments to Part D plans reflect the expected drug costs to plans given their enrolled population.
  - CMS calculates risk scores for each beneficiary to use in calculating payments.
  - Beneficiaries get different risk scores depending on whether they are low income or non-low income.
  - CMS sets the average, program-wide risk score across all Part D enrollees to 1.0.
  - Risk scores greater than 1.0 mean that spending is expected to be higher than the average, and risk scores less than 1.0 mean that spending is expected to be lower than the average.
  - If the enrolled population is expected to be more costly or less costly than the average, risk adjustment ensures that plan payments account for that difference in risk.

Part D Risk Adjustment Model (RxHCC)

- CMS uses diagnoses and demographic characteristics to predict drug spending for each beneficiary under the basic drug benefit relative to the average cost beneficiary.
  - In Part D, diagnoses are grouped into prescription drug hierarchical condition categories (RxHCCs) based on severity and cost, so the model is referred to as the RxHCC model.
- Since the Part D risk adjustment model predicts plan liability specifically for drug costs and the Medicare Advantage risk adjustment model (CMS-HCC) predicts medical costs, they have multiple differences:
  - The Part D model may include some conditions that are not in the MA model if those conditions are stronger predictors of drug costs than medical costs.
  - Where the same conditions are in both models, coefficients will be different because they are predicting drug costs in the Part D model, as opposed to medical costs in the MA model.

RxHCC Model Development

RxHCC Model Overview

- CMS periodically updates the RxHCC model to reflect more recent trends in drug costs and utilization and updates to the Part D benefit structure.
- Changes to the RxHCC model are proposed in the Advance Notice and finalized in the Rate Announcement.
- The RxHCC model is calibrated using historical diagnostic, demographic, and cost data to predict drug costs for which Part D plans are liable under the basic Part D benefit.
  - Excludes costs paid for entirely by the government: reinsurance and the low-income subsidy
  - Excludes enhanced benefits provided above and beyond the defined standard benefit structure
- The current RxHCC model was updated last year for payment beginning in 2023 and is calibrated using 2018 diagnosis information to predict 2019 expenditures.
  - The 2023 RxHCC model was the first time an RxHCC model was calibrated with ICD-10 diagnoses. It contains 84 payment RxHCCs.

Key Data Elements for the RxHCC Model

- **Demographic information**, such as beneficiary age, sex, disability status, low income, and long-term institutional status, is obtained from CMS administrative data.

- **Diagnosis information**: each beneficiary's diagnosis information is used, whether they are enrolled in Medicare Advantage (MA) or Traditional Medicare/Fee-for-Service (FFS) for their medical care, collected from FFS claims and MA encounter data.

- **Gross expenditures** are collected from Prescription Drug Event (PDE) data.

RxHCC Model Structure

- The RxHCC model produces separate risk scores for different subsets of Part D enrollees based on time in the program, low-income status and institutional status, and age.
- There are eight unique beneficiary subsets ("segments"):
  - Five segments are for continuing enrollees, which refer to beneficiaries who had 12 months of enrollment in Part D benefits in the base year (when diagnosis information is collected).
    - Community, Non-Low Income, Age 65+
    - Community, Non-Low Income, Age<65
    - Community, Low Income, Age 65+
    - Community, Low Income, Age < 65
    - Institutional

RxHCC Model Structure (continued)

- Three segments are for new enrollees, who are beneficiaries with fewer than 12 months of enrollment in Part B in the base year.
  - Non-Low Income
  - Low-Income
  - Institutional
- The RxHCC model uses diagnoses from one year (a base year), along with demographic information, to predict plan spending the following year (payment year).
- The RxHCC risk adjustment model is budget neutral, in that the average risk score is set to 1.0 across the Part D market, including both FFS (PDP) and MA beneficiary (MA-PDs) populations.

RxHCC Model Structure (cont.)

- Only diagnoses that are reliable predictors of drug costs in the following year are used in the model.

- Individuals in stand-alone drug plans (PDPs) are enrolled in traditional Medicare, so the diagnosis data source is FFS claims; individuals in MA drug plans (MA-PDs) are enrolled in MA so diagnoses come from MA encounter data.

Diagnosis Groupings (RxHCCs)

- RxHCCs are evaluated for inclusion in the model for payment based on 10 model principles, similar to the CMS-HCC (MA) model:

  1. Diagnostic categories should be clinically meaningful.

  2. Diagnostic categories should predict prescription drug expenditures.

  3. Diagnostic categories that will affect payments should have adequate sample sizes to permit accurate and stable estimates of prescription drug expenditures.

  4. In creating an individual's clinical profile, hierarchies should be used to characterize the person's illness level within each disease process, while the effects of unrelated disease processes accumulate.

  5. The diagnostic classification should encourage specific coding.

Diagnosis Groupings (RxHCCs) (cont.)

- RxHCCs are evaluated for inclusion in the model for payment based on 10 model principles (continued below), similar to the CMS-HCC (MA) model:

  6. The diagnostic classification should not reward coding proliferation.

  7. Providers should not be penalized for recording additional diagnoses (monotonicity).

  8. The classification system should be internally consistent (transitive).

  9. The diagnostic classification should assign all ICD-9-CM and ICD-10 CM codes (exhaustive classification).

  10. Discretionary diagnostic categories should be excluded from payment models.

Mapping Costs into RxHCC Model

- The RxHCC model uses gross historical expenditure data from Prescription Drug Event (PDE) data, which includes information about plan spending on drugs.

- Since PDE data are from prior years, individual PDEs reflects costs paid by plans, beneficiaries, and the government for the benefit structure in that year.

- Because the RxHCC model is used to predict drug spending in a future year when the benefit will be different, each PDE needs to have its allocation of payment re-mapped onto the standard benefit structure for the payment year.

Mapping Costs into RxHCC Model (cont.)

- For each PDE in the year used for calibrating model expenditures, gross drug costs are re-mapped among the plan, the beneficiary, the government, and manufacturer discounts according to the benefit design in the future payment year.

- This re-mapping is especially important for 2025 payment since the Inflation Reduction Act (IRA) redesigned the benefit such that these cost-sharing allocations are substantially different than prior years.

- The spending totals used to calibrate the model are to reflect how much a plan would have spent for a drug if the future payment year's basic benefit structure was in place at the time of the original PDE.

IRA Updates to Part D Benefit for CY2025

IRA Updates to Part D Benefit

- The IRA includes a series of changes to the Part D standard benefit. These changes increase Part D plan liability under the basic benefit and will be incorporated into the RxHCC model for 2025.
  - Capped beneficiary cost-sharing for covered insulin products and elimination of beneficiary cost-sharing for adult vaccines
  - Reduced out-of-pocket threshold for drug costs ($2,000 in 2025)
  - Elimination of coverage gap phase of the Part D benefit
  - Elimination of beneficiary cost-sharing (in 2024) and reduction in Medicare reinsurance percentage (in 2025) in catastrophic phase
  - Replacement of the Coverage Gap Discount Program (CGDP) with the Manufacturer Discount Program (MDP)
  - Cost-sharing reductions due to supplemental benefits counting toward the out-of-pocket threshold
- In addition to IRA updates, the model also will account for oral-only ESRD drugs that will be covered under Part B instead of Part D starting in 2025 due to the ESRD PPS final rule.

- IRA changes to the Part D benefit decrease beneficiary liability across all subgroups of beneficiaries and increase plan liability.

- Key changes include lowering the maximum out of pocket limit to $2,000, changing of the manufacturer discount cost-sharing proportions, and reduction in Medicare reinsurance, etc.

- There are different cost-sharing arrangements for brand and generic drugs, and low-income individuals have additional changes that will impact plan liability for those beneficiaries specifically (next slide).
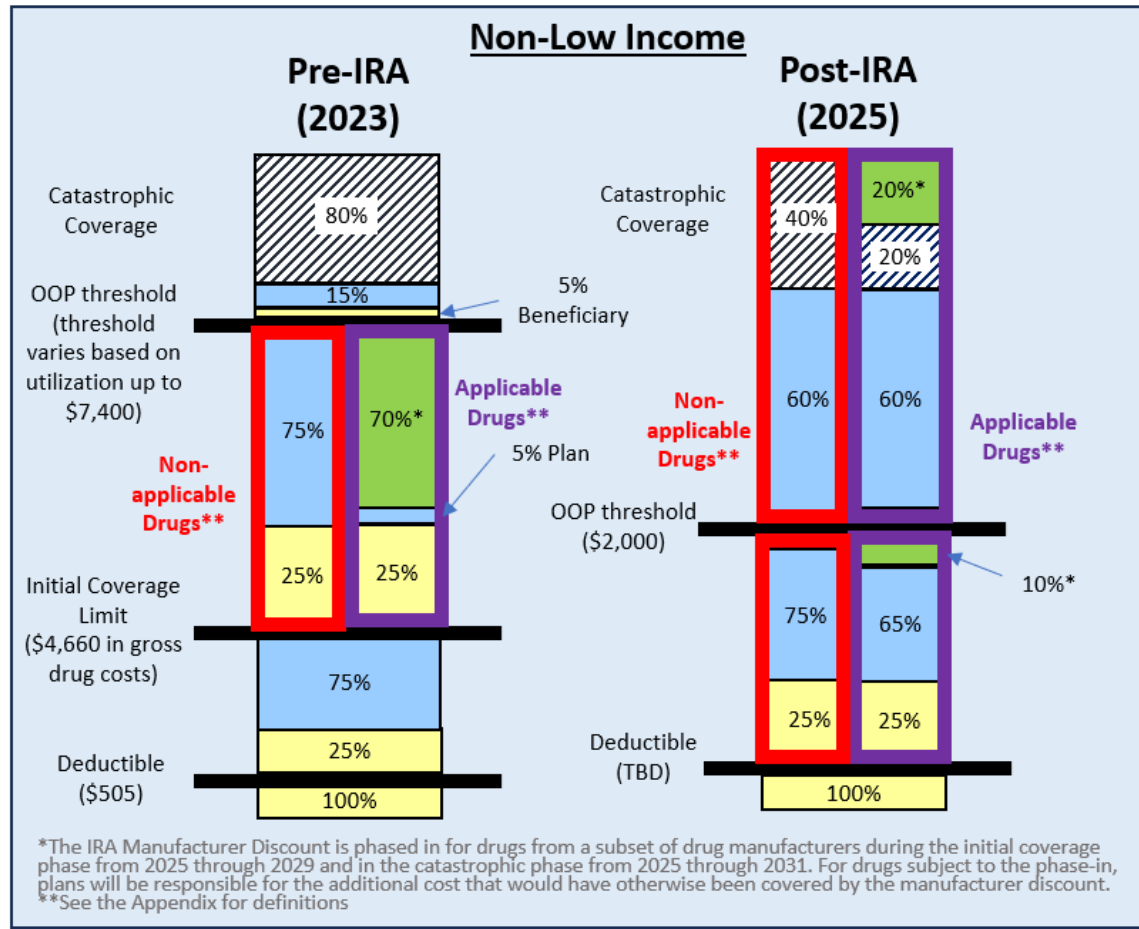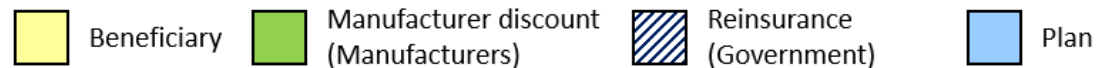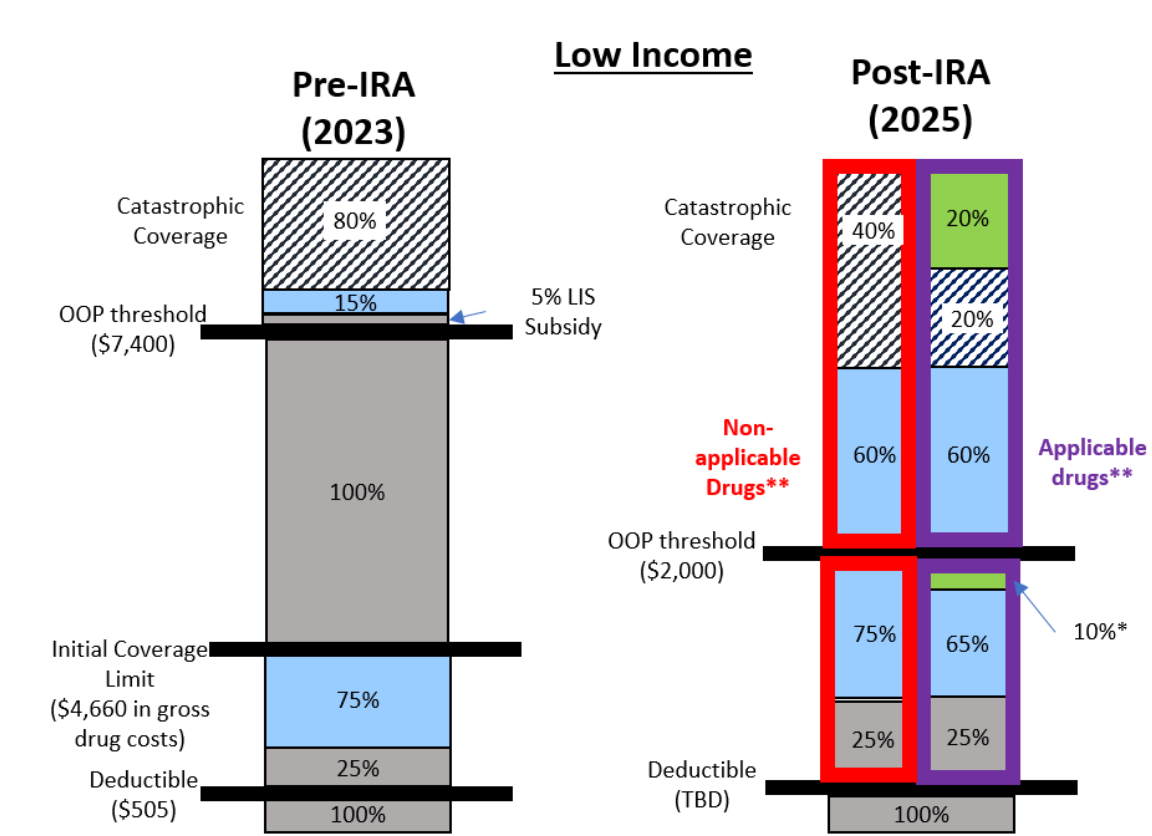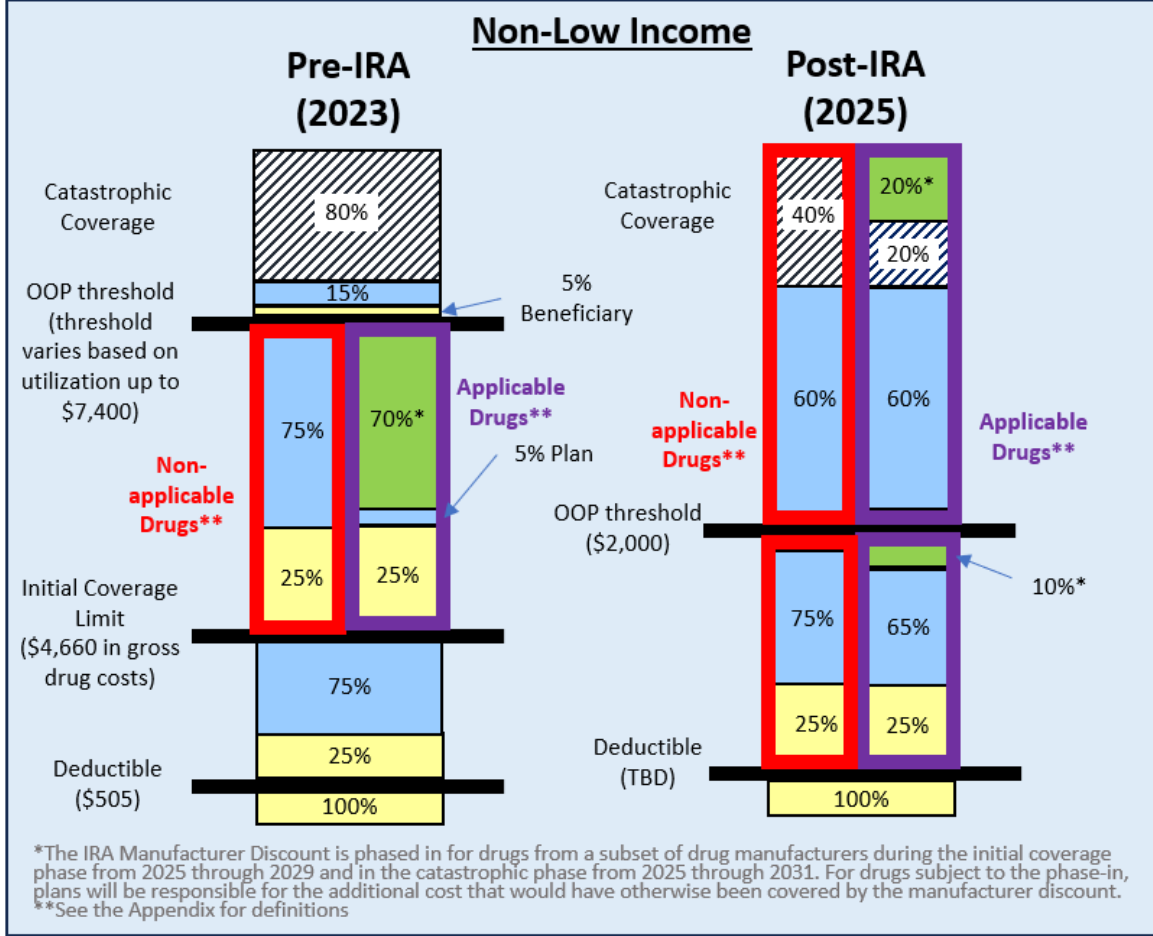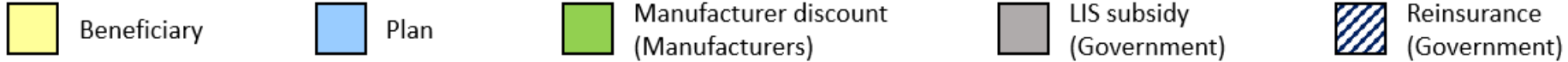

*The IRA Manufacturer Discount is phased in for drugs from a subset of drug manufacturers during the initial coverage phase from 2025 through 2029 and in the catastrophic phase from 2025 through 2031. For drugs subject to the phase-in, plans will be responsible for the additional cost that would have otherwise been covered by the manufacturer discount.
**See the Appendix for definitions

IRA Impact on Plan Liability for Low-Income Beneficiaries

- The elimination of the coverage gap phase of the benefit results in an increase in plan liability for low-income enrollees that is larger than the increase in plan liability for non-low-income beneficiaries.

  - Previously, the low-income subsidy covered all costs during the coverage gap phase.

  - With the elimination of the coverage gap phase, drug costs that previously were covered by the low-income subsidy will largely be shifted to plan liability (i.e., part of the bid that is risk adjusted).

*The IRA Manufacturer Discount is phased in for drugs from a subset of drug manufacturers during the initial coverage phase from 2025 through 2029 and in the catastrophic phase from 2025 through 2031. For drugs subject to the phase-in, plans will be responsible for the additional cost that would have otherwise been covered by the manufacturer discount.
**See the Appendix for definitions

Updates to RxHCC Model for IRA Benefit Changes

- The RxHCC model will be calibrated for CY2025 mapped to the new standard benefit structure that will apply in 2025.

- In addition to the standard re-mapping of PDEs to the new cost sharing requirements the 2025 update required adjustments to account for the benefit change:

  - Because the out-of-pocket threshold in 2025 will be $2,000, which is lower than the OOP threshold in previous years, we decreased the OOP Threshold from the payment year ($5,100 in 2019) using annual percentage increase to calculate the equivalent IRA OOP threshold ($1,550 in 2019) to include in the model such that the difference between the deductible and out-of-pocket threshold would be similar in 2019 to how it will be in 2025.

Updates to RxHCC Model for IRA Benefit Changes (cont.)

- In addition to the standard re-mapping of PDEs to the new cost sharing requirements the 2025 update required adjustments to account for the benefit change:

  - Additionally, under the new Manufacturer Discount Program (MDP), some drugs from specified manufacturers are eligible for a phased-in manufacturer discount, so we estimated which drugs would be applicable for a discount by examining Part D and Part B expenditure data and available manufacturer information. A full list will be available for CY2026 and beyond once manufacturers have reported complete ownership information in signing up for the MDP.

Potential Impact of Benefit Changes for Low-Income and Non-Low-Income Beneficiaries

- As discussed on the previous slides, plan liability for low-income beneficiaries is expected to increase more than the plan liability for non-low-income beneficiaries under the new benefit structure.
  - Therefore, the relative risk of low-income beneficiaries is expected to increase more than the overall average risk, and the relative risk of non-low-income beneficiaries is increasing less than the average.
- The overall average risk score across the entire Part D program is 1.0
  - The risk scores of low-income beneficiaries are expected to increase
  - The risk scores of non-low-income beneficiaries are expected to decrease.

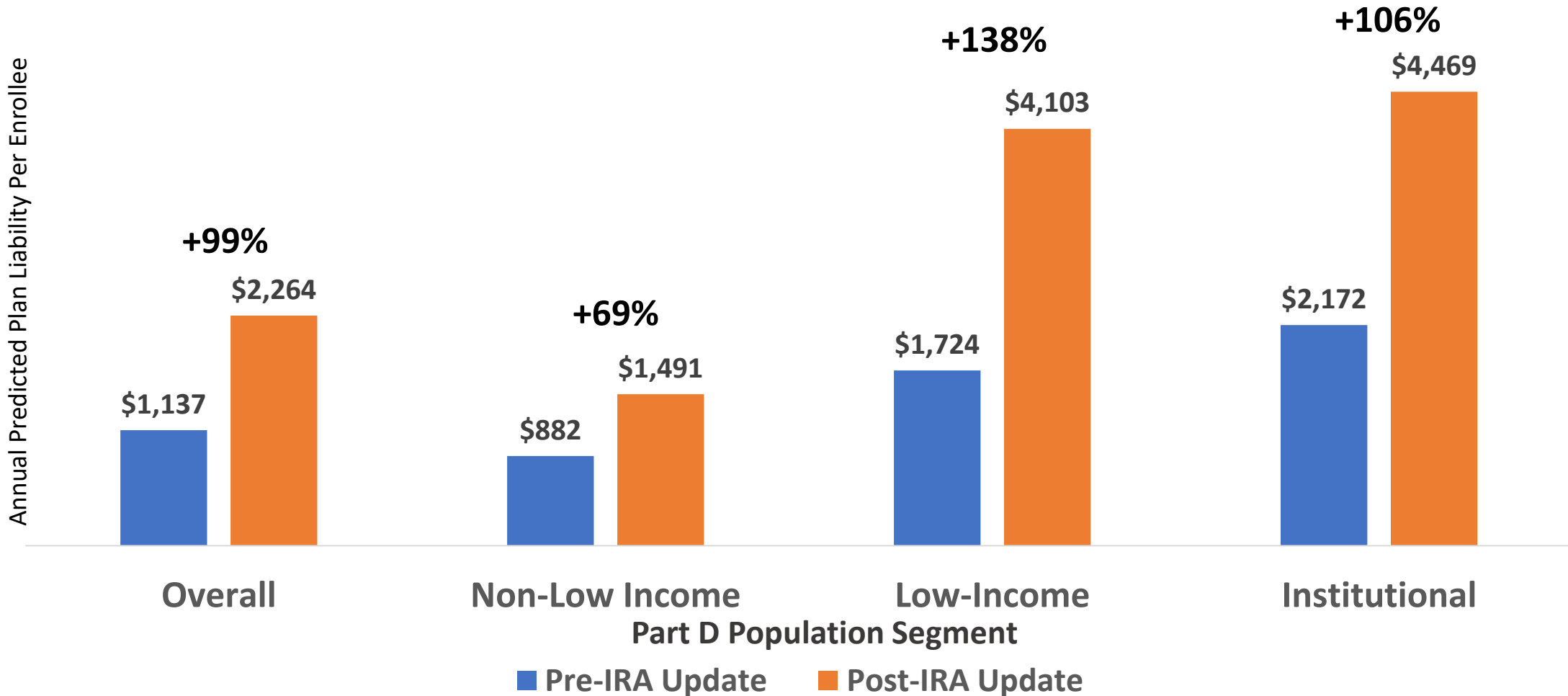# Early Predicted Plan Liability Results for CY2025 Model

Early Predicted Plan Liability Results

- The next few slides will present information on the change in predicted annual plan liability from moving from the current benefit structure (pre-IRA update) to the benefit structure that will be in effect for 2025 (post-IRA update).

  - Both pre-update and post-update statistics in these slides are based on 2018 diagnoses predicting 2019 expenditures.
  - CMS is evaluating options for more recent data years to use for the model calibration.

Early Predicted Plan Liability Results (cont.)

- Plan liability in these statistics refers to gross liability where the plan is at risk. It does not account for manufacturer rebates or other direct and indirect remuneration (DIR).

- The only difference between the pre-IRA update and post-IRA update statistics is the change in benefit structure (e.g. no RxHCC classifications or number of payment RxHCCs).

- Note: Separate from the IRA, there will be decreased liability for oral-only ESRD drugs, which is expected to reduce Part D plan liability for ESRD beneficiaries.

Average Predicted Annual Plan Liability Increases, Pre-IRA and Post-IRA Updates (PY2019)

Takeaways from Predicted Plan Liability Results

- Impacts of the model update on risk scores at the plan level will depend on how the beneficiary population in each plan compares to the average cost beneficiary.

- Risk scores for plans enrolling disproportionately more low-income beneficiaries are expected to increase, while plans disproportionately enrolling more non-low-income beneficiaries are expected to decrease, in order to keep the average at 1.0 across the market.

Measuring Model Predictive Accuracy: Predictive Ratios

- We use predictive ratios to assess the performance of risk adjustment models.

- Predictive ratios measure the ratio of predicted plan spending to actual plan spending for groups of beneficiaries.

  - Predictive ratios of 1.0 mean that the model perfectly predicts plan spending.

  - Predictive ratios of less than 1.0 mean that the model underpredicts plan spending.

  - Predictive ratios of greater than 1.0 mean that the model overpredicts plan spending.

- As with the predicted annual plan liability increases presented earlier, these ratios are based on 2018 diagnoses predicting 2019 expenditures and reflect the post-IRA model predicting spending under the post-IRA benefit design.

Predictive Ratios for Post-IRA Model – Continuing Enrollee Model Segments by Spending Decile

Post-IRA Model and Post-IRA Plan Liability

Spending Decile	Non-Low Income (65+)	Low-Income (65+)	Non-Low Income (<65)	Low-Income (<65)	Institutional
Overall	**1.01**	**1.01**	**1.00**	**1.00**	**1.00**
First (lowest) decile	0.88	0.79	1.29	1.40	0.73
Second decile	1.29	1.37	1.33	1.35	0.92
Third decile	1.42	1.14	1.04	1.15	0.99
Fourth decile	1.27	1.08	1.05	1.08	1.03
Fifth decile	1.04	1.03	1.03	1.02	1.06
Sixth decile	0.96	1.03	0.98	0.96	1.05
Seventh decile	0.96	1.02	1.00	0.99	1.03
Eighth decile	0.94	0.98	0.96	0.93	1.02
Ninth decile	0.96	0.96	0.95	0.95	1.00
Tenth (highest) decile)	1.01	0.99	0.99	1.01	0.98

Takeaways from Predictive Ratio Results

- The post-IRA model accounts for the increase in predicted plan liability, particularly in high-cost deciles.

- Predictive ratios are near 1.0 for the highest deciles of predicted risk across segments, which is especially important given the increase in plan liability for the highest cost beneficiaries.
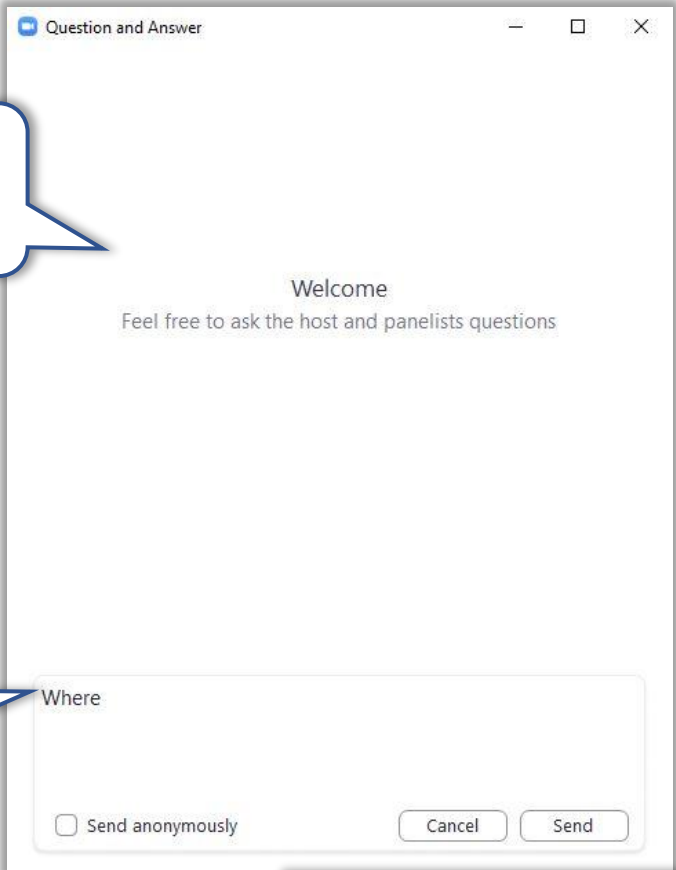
Question and Answer Session

Ask Questions During the Q&A Session

Your questions and any answered questions will appear here.

Type your question in the Q&A box and press the Send button.

Select the Q&A button on the toolbar at the bottom of your screen to open the Q&A box.

Resources and Appendix

Resources

Resource	Description
Advance Notices/Rate Announcements	The Advance Notices and Rate Announcements for each year are archived on the CMS website.
CMS Risk Adjustment Webpage	Located on CMS.gov, the Risk Adjustment webpage hosts information and resources on risk adjustment, including this slide deck.
Risk Adjustment Methodology Computer-Based Training Series	View this training series, which includes an overview of risk adjustment, a walkthrough of how risk scores are calculated, and example calculations, on the CMS CSSC Operations website.
User Group Slide Decks	The slide decks for previous user groups on various topics, including the Rate Announcement, Risk Adjustment for PACE Organizations, and the MAO-004 report are located on the CMS CSSC Operations website.
Customer Support & Service Center (CSSC) Operations	The CMS CSSC website includes a wealth of resources including training, job aids, and slide decks from previous user groups.
Health Plan Management System (HPMS)	Memos and emails sent from CMS to MA plans are archived on the HPMS website. Sign up for the listserv to receive announcements.
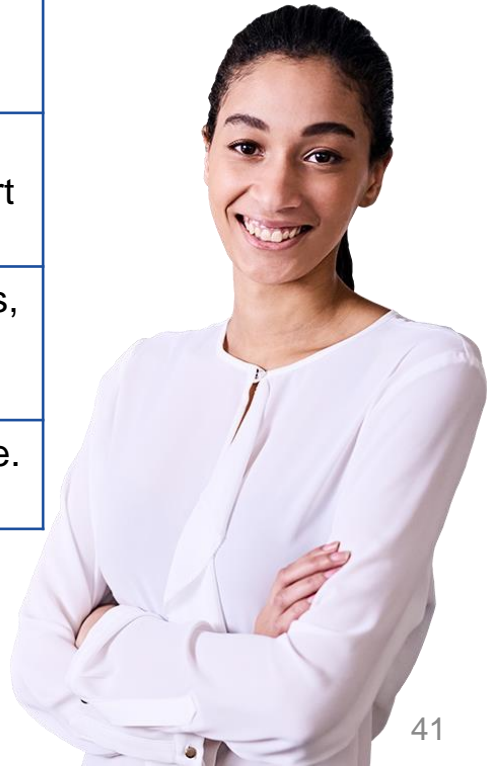
Definitions

- **Applicable Drugs**: Part D drugs approved under a new drug application (NDA) or biologics license application (BLA), including biosimilar products licensed under section 351(k) of the Public Health Service Act, other than a drug selected for Medicare negotiation. In other words, brands and biologics.

- **Non-Applicable Drugs**: Generics and drugs selected for Medicare negotiation.

Overall Average Predicted Annual Plan Liability Increases (PY2019)

The average predicted annual gross plan liability approximately doubles from the pre-IRA update to the post-IRA update for payment year 2019.

	Pre-IRA Update Average Predicted Annual Gross Plan Liability	Post-IRA Update Average Predicted Annual Gross Plan Liability	Percent Change (Pre-IRA to Post-IRA)
Overall	$1,137.46	$2,264.20	99%

Average predicted annual gross plan liability increases more for low income beneficiaries and increases less for non-low income beneficiaries in payment year 2019.

Continuing Enrollee Model Segment	Percent of total beneficiary population (PY2019)	RxHCC Model (2018 diagnoses used to predict 2019 expenditures)		
		Pre-IRA Update Average Annual Predicted Gross Plan Liability	Post-IRA Update Average Annual Predicted Gross Plan Liability	Percent Change (Pre-IRA to Post-IRA)
Community, Low Income, Age < 65	10%	$2,067.90	$5,382.00	160%
Community, Low Income, Age 65+	15%	$1,550.36	$3,389.51	119%
Institutional	2%	$2,166.86	$4,453.68	106%
Community, Non-Low Income, Age < 65	3%	$1,285.33	$2,554.02	99%
Community, Non-Low Income, Age 65+	61%	$880.39	$1,464.94	66%

Segment	Percent of total beneficiary population (PY2019)	RxHCC Model (2018 diagnoses used to predict 2019 expenditures)		
		Pre-IRA Update Average Annual Predicted Gross Plan Liability	Post-IRA Update Average Annual Predicted Gross Plan Liability	Percent Change
Low Income	3%	$1,399.56	$3,251.09	132%
Institutional	<1%	$2,412.18	$5,072.13	110%
Non-Low Income	7%	$687.56	$1,176.86	71%