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CMS's 2024 Updates to Risk-Adjustment Model

Beginning January 1, 2024, the Centers for Medicare and Medicaid Services (CMS) updated its Medicare Advantage (MA) Capitation Rates, as well as Part C and Part D Payment Policies, which finalized the switch to a revised CMS-Hierarchical Condition Category (HCC) risk-adjustment model, Version 28 (V28).[1] The last version of the CMS-HCC risk-adjustment model, Version 24 (V24), was released in 2020.[2] The changes in the CMS-HCC risk-adjustment model V28 impact multiple programs, including MA, the Medicare Shared Savings Program (MSSP), and the Accountable Care Organization (ACO) Realizing Equity, Access, and Community Health (REACH) Model.[3] This Health Capital Topics article discusses the various changes and updates included in the recently-enacted version of the risk-adjustment model.

HCCs have been used by CMS since 2004 as a part of the risk-adjustment model, which identifies patients with serious acute or chronic conditions.[4] HCCs are sets of medical codes that are tied to certain clinical diagnoses.[5] By using HCCs, CMS is able to project the expected risk from patients, as well as the future cost of care.[6] RAF scores are also an integral part of the risk-adjustment model that CMS uses to estimate the cost of caring for beneficiaries, and the score determines the amount CMS will pay health plans and providers per beneficiary during the corresponding payment year.[7] RAF scores are based on both disease risk scores and demographics.[8] Disease risk scores are based on the diagnoses from patient encounters and their corresponding HCC codes, and the demographic score is based on sex, age, and residence (i.e., in a skilled nursing facility, the community, or other institution).[9] A higher RAF score can indicate a sicker patient, while a lower RAF score can indicate a healthier patient.[10] However, low RAF scores could also indicate inaccuracy in coding due to a gap in care or the patient record lacking information.[11]

In general, CMS updated its CMS-HCC risk-adjustment model to V28 to reflect recent diagnostic, cost, and utilization patterns.[12] Aside from improving payment accuracy, the risk-adjustment model will also reduce differences in coding between fee-for-service (FFS) providers and MA plans.[13] The risk-adjustment model will require greater specificity in code assignment and documentation to ensure the level of all patients' illness severity is appropriately represented.[14] By requiring this level of specificity, CMS will be able to collect data on the severity of patient illnesses, and take the data into consideration when recommending changes in future risk-adjustment models.[15]

CMS-HCC risk-adjustment model V28 will be phased in over three years as follows:

For services provided during 2023, a blend of risk-adjustment model V24 (67%) and risk-adjustment model V28 (33%) was used;

(1) For services provided during 2024, a more updated blend of risk-adjustment model V24 (33%) and risk-adjustment model V28 (67%) is being used; and
(2) For services provided during 2025, solely risk-adjustment model V28 (i.e., 100%) will be used.[16]

Due to changes in the risk-adjustment model V28, navigating both V24 and V28 in concert could create challenges for providers.[17] Conditions that may be considered an HCC in one version may not be considered an HCC in the other.[18] Even if a diagnosis is an HCC in both V24 and V28, the actual risk-adjustment factors (RAFs) and HCC may differ.[19]

The major changes included in V28 include:

(1) An expanded number of HCCs;
(2) A change in how the V28 HCC codes are numbered and named;
(3) Changes to ICD-10-CM code to HCC mappings;
(4) Changes to coefficient values for HCCs;
(5) Addition of 268 diagnosis codes that did not map to payment CMS-HCC in V24; and
(6) Removal of 2,294 diagnosis codes that no longer map to a payment HCC.[20]

The CMS-HCC risk-adjustment model, which is applicable to a specific calendar year, is used to identify a Medicare FFS beneficiary's prospective HCC risk score for the corresponding year.[21] Based on an analysis of the MSSP, CMS found that using different CMS-HCC risk-adjustment models negatively impacts: (1) ACOs with the highest average risk scores; (2) ACOs that have participated in MSSP longer; and (3) ACOs that participate in two-sided models.[22] These changes to the risk-adjustment model impact HCCs, RAF scores, and how medical practices and health plans allocate resources and manage patient risk.[23]

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The changes to the CMS-HCC risk-adjustment model are likely to create challenges for MA Organizations (MAOs), MSSP ACOs, REACH ACOs, and other stakeholders.[24] With these changes, the administrative burden on revenue cycle staff could increase, and access to care could be hindered for beneficiaries with chronic conditions.[25] Organizations will need to continue keeping track of member health statuses and analyze how these changes will impact them.[26] The American Medical Group Association (AMGA) expressed its concern with V28, recommending that CMS reconsider their "continued phase-in of the new CMS-HCC model."[27]

Industry experts suggest that providers and health plans should identify the most common HCCs among their patient population to understand the impact of the two versions of the risk-adjustment model.[28] Experts also advise that investing in technology that allows for specificity in documentation and accurate coding of clinical documentation will be vital to enable providers, health plans, and other stakeholders to manage their respective risk-adjustment programs.[29]

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