CMS final rule
Risk adjustment changes 2023

Medicare Risk Adjustment Programs

HealthSun HEALTH PLANS

Medicare Advantage

Disclaimer

- This training is based on coding guidelines from the Official ICD-10-CM Coding Guidelines, American Hospital Association's (AHA) Coding Clinic, and/or CMS guidance and guidelines.
- The ICD-10-CM code set is updated annually. Coding requirements and standards are subject to change, potentially impacting the accuracy of the content contained within this presentation. The individuals assigning ICD-10-CM codes are reminded to verify the accuracy, specificity, currency, and acceptability of such codes, coding methods, and supporting documentation requirements by referencing official sources with up-to-date information. This guidance is not intended to replace the provider's independent clinical judgment and expertise.
- The contents included in this presentation are for informational purposes only. We do not guarantee that the information supplied is without defect. Every attempt has been made to ensure its accuracy, completeness, and relevance. Do not copy (in any form) without our written consent.

HealthSun HEALTH PLANS

Risk adjustment background

- The *Balanced Budget Act of 1997* (*BBA*) mandated that the risk adjustment model be used as the payment methodology for Medicare Advantage plans:
  - The methodology was gradually implemented from 2000-2007 using a **blending** approach.
  - In 2007, the first risk adjustment model was fully implemented.
  - Several model versions have been implemented since then.
- The CMS premium payment to Medicare Advantage Organizations (MAOs) is adjusted for each enrollee to account for the expected costs of care:
  - Designed to encourage efficiencies and quality of care rather than the ability to attract low-risk individuals and deter those who may be characterized as high-risk

HealthSun HEALTH PLANS

Risk adjustment background

- Risk scores are calculated, in part, based on diagnoses documented and reported by providers to MAOs and subsequently submitted to CMS:
  - Risk scores are intended to reflect a patient's expected healthcare costs based on accurate and complete diagnosis coding of certain conditions[1] documented by providers managing and treating Medicare Advantage patients.
- Each provider-patient encounter should center on providing quality clinical care **and** accurately and completely documenting, as applicable based on the provider's evaluation and independent clinical judgment, conditions that exist at the time of the encounter and require or affect patient care, treatment, or management:
  - By maintaining this focus, the risk score calculation should more accurately reflect the true health status for each given patient.

Important: Because the composition and health status of a provider's panel of patients changes constantly and is not directly related to the quality of care rendered by the provider, risk scores should not be solely relied upon to indicate accurate and complete documentation and coding. Risk score information should not be used to set performance targets for or by provider organizational or individual providers.

HealthSun HEALTH PLANS

[1] As outlined on previous slides, only a subset of conditions map to the CMS-HCC Risk Adjustment model.

4

CMS changes

On March 31, 2023, CMS released the final Announcement of Calendar Year (CY) 2024 Medicare Advantage (MA) Capitation Rates and Part C and Part D Payment Policies (Final Rate Announcement). At the same time, CMS released a CMS Fact Sheet summarizing the key provisions addressed in the Final Rate Announcement.

As proposed in the Advance Notice, CMS restructured the condition categories based on the ICD-10-CM classification system (as opposed to the ICD-9-CM system) and reclassified certain diagnoses and condition categories based on coding in MA versus fee for service (FFS).

CMS finalized the 2024 proposed Part C model and announced that the 2024 model will be phased in over a [three]-year period.

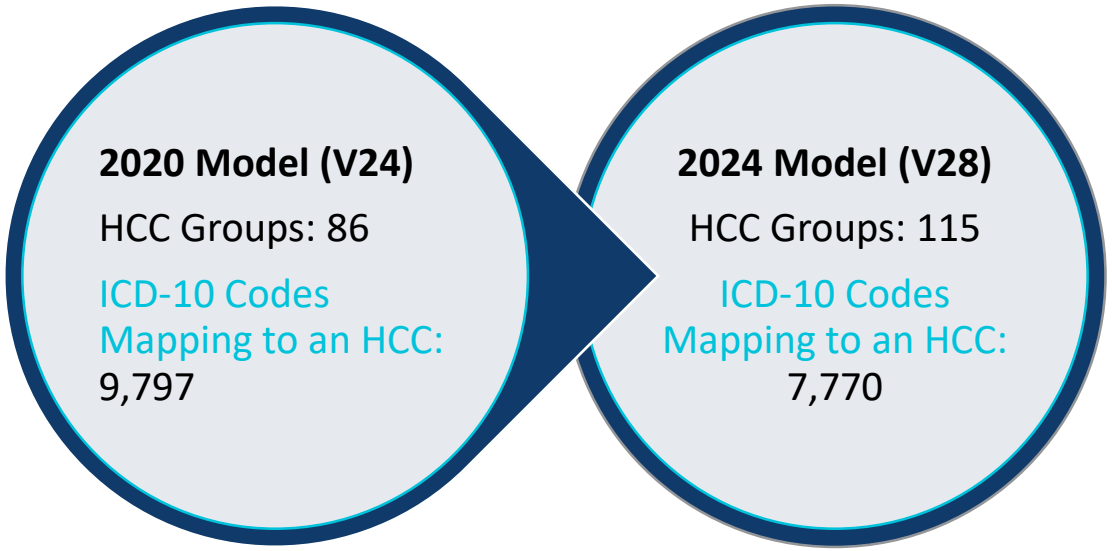
Source: CMS Announcement of Calendar Year (CY) 2024 Medicare Advantage Capitation Rates and Medicare Advantage and Part D Payment Policies and Final Call Letter. Published March 31, 2023. cms.gov/files/document/2024-announcement-pdf.pdf

Note: For additional information, you may review the entire CMS "Announcement of Calendar Year (CY) 2024 Medicare Advantage (MA) Capitation Rates and Part C and Part D Payment Policies."

HealthSun HEALTH PLANS

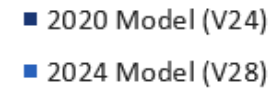
CMS 2024 final rate announcement

CMS-HCC models
2023-2025 years of service

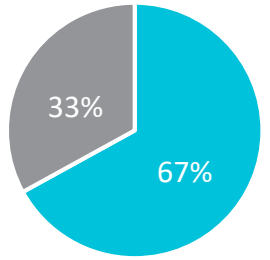


Source: CMS Final ICD-10 HCC Mappings (FY 2022 and FY 2023); there are 86 payment HCCs included in the 2020 Alternative Payment Condition Count (APCC) Model; CMS Medicare Managed Care Manual, Ch. 7 Risk Adjustment

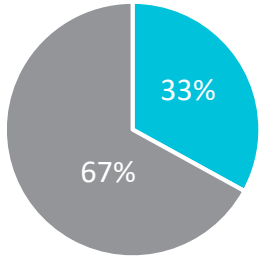
Risk Model Blend
2024-2026 Payment Years



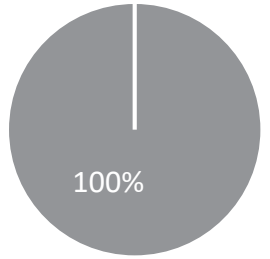
Service Year: 2023
Payment Year: 2024



Service Year: 2024
Payment Year: 2025



Service Year: 2025
Payment Year: 2026



HealthSun HEALTH PLANS

2020 Model (V24) vs 2024 Model (V28)

CMS made significant changes to the structure of the HCC model in V28, which include the following:

- Addition of 268 diagnosis codes that did not map to an HCC in V24
- Removal of 2,297 diagnosis codes that no longer map to an HCC
- Changes to HCC coefficient values
- How the V28 HCC codes are named and numbered
- Changes to ICD-10 CM code to HCC mappings
- An expanded number of HCCs

Source: ICD-10-to-HCC mappings for the revised model proposed for CY 2024 posted on the CMS Risk Adjustment.
cms.gov/files/zip/py-2024-proposed-clinical-revision-part-c-model-icd-10-mappings.zip

Note: For additional information, you may review the entire CMS "Announcement of Calendar Year (CY) 2024 Medicare Advantage (MA) Capitation Rates and Part C and Part D Payment Policies."

HealthSun HEALTH PLANS

Thank you

https://provider.healthsun.com

HealthSun Health Plans is a Medicare-contracted coordinated care plan that provides benefits or arrange for benefits to be provided to enrollees. Enrollment in HealthSun Health Plans depends on contract renewal.