The transition from CMS-HCC V24 to V28:

Impacts and strategic steps

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Key takeaways

The transition from CMS-HCC V24 to V28 heralds a significant shift in risk adjustment methodologies, impacting Medicare Advantage plans, ACOs, and other healthcare entities. This transition, effective January 1, 2024, emphasizes **improved accuracy and granularity, promising more equitable resource distribution and significant financial implications for providers**. To navigate this change effectively, organizations must act swiftly.

Engage our consultants to conduct a rapid assessment and develop a comprehensive plan tailored to your organization's needs.

Immediate steps include:

Conduct a rapid data audit and impact analysis

Review the current data landscape and its potential implications under V28.

Assess and educate clinical teams and coding staff

Ensure staff readiness and proficiency with the new model through comprehensive training.

Implement analytical surveillance systems

Establish systems to monitor the impact of V28, enabling proactive adjustments and informed decision-making.

By proactively addressing these steps, organizations can position themselves for success in the evolving healthcare landscape under CMS-HCC V28.

Overview

The Centers for Medicare & Medicaid Services (CMS) recently announced a **significant transition in its risk adjustment model**, moving from Version 24 (V24) to Version 28 (V28).

Effective **January 1, 2024**, this change will impact Medicare Advantage (MA) plans, accountable care organizations (ACOs), and other populations within the healthcare system. This ebook explores the implications of this transition, focusing on the financial impacts and strategic steps organizations should consider.

Impact on Medicare Advantage members

The transition to V28 aims to improve the accuracy of risk adjustment by incorporating updated clinical and demographic factors. This change is expected to result in **more precise risk scores for Medicare Advantage members**, aligning payment rates more closely with their actual health status.

This enhanced accuracy will potentially lead to adjustments in premiums and benefits for MA members. Those with higher risk scores under the new model may benefit from more resources directed towards their care, while those with lower risk scores might see modifications in their plan offerings.

Impact on ACO members

For ACO members, the consistent application of V28 in both benchmark and performance years promises significant improvements. Using different models in past years often disadvantaged ACOs with higher average risk scores and those participating in two-sided models.

The new approach addresses those issues, providing a **stable and predictable framework for risk adjustment**. This consistency will allow ACOs to better predict their financial performance, make informed decisions about care management, and allocate resources more effectively—which is crucial for long-term planning and sustainability.

Impact on other populations

The revised model also has important implications for other populations, particularly in promoting equity in healthcare access.

By incorporating more recent data and a broader range of health conditions, V28 aims to **ensure a fairer distribution of resources**. Vulnerable populations, such as those with chronic conditions or multiple comorbidities, are likely to receive more appropriate funding and care under the new model.

Additionally, V28 aligns with current healthcare trends and treatment protocols, ensuring that the risk adjustment process remains relevant and effective in capturing the complexity of patients' health statuses.

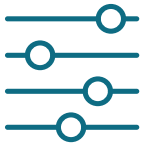
Other impacts

Expected CMS savings

CMS anticipates significant savings from the transition to V28, estimating that the enhanced accuracy and updated factors will reduce unnecessary payments.

CMS predicts a 3.12% decrease in MA risk scores by CY 2025 and $11B in savings for the Medicare trust fund in 2024.

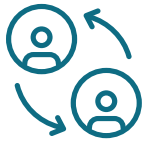
With even more savings expected over the next decade, CMS hopes these changes will improve the overall efficiency of the Medicare program.



Reimbursement adjustments for providers

One of the primary financial impacts will be changes in reimbursement rates for providers. As risk adjustment becomes more precise, some providers may see lower reimbursements—particularly if their patient populations are found to have lower-than-estimated risk scores.

Conversely, providers with high-risk populations that align well with the new model's parameters may see increased payments.



Changes in key HCCs

Several hierarchical condition categories (HCCs) with high disease prevalence have either moved out of the model or have become more granular under V28.

For example, certain chronic conditions like diabetes and heart disease have been refined to capture more specific sub-conditions, improving the accuracy of risk scores. However, some conditions previously included may no longer be covered, potentially affecting reimbursement rates for providers treating these conditions.

Differences between V24 and V28

The changes between the 2020 model (V24) and the proposed 2024 model (V28) are significant.

V24	V28
86 payment HCCs	**115** payment HCCs
9,797 FY22/FY23 ICD-10 diagnosis codes mapped to an HCC for payment	**7,770** FY22/FY23 ICD-10 diagnosis codes mapped to an HCC for payment

These adjustments reflect a more granular approach in V28, potentially leading to more accurate risk adjustment and better resource allocation.

To highlight how V28 gets more granular, consider the examples in HCC numbering and categorization in the following pages.

	V24	V28
Endocrine and Metabolic Disorders	**HCC 23** Other Significant Endocrine and Metabolic Disorders	**HCC 50** Amyloidosis, Porphyria, and Other Specified Metabolic Disorders **HCC 51** Addison's and Cushing's Diseases, Acromegaly, and Other Specified Endocrine Disorders
Liver Disease Group	**HCC 27** End-Stage Liver Disease **HCC 28** Cirrhosis of Liver **HCC 29** Chronic Hepatitis	**HCC 62** Liver Transplant Status/Complications **HCC 63** Chronic Liver Failure/End-Stage Liver Disorders **HCC 64** Cirrhosis of Liver **HCC 65** Chronic Hepatitis **HCC 68** Cholangitis and Obstruction of Bile Duct without Gallstones
Gastrointestinal Disease Group	**HCC 33** Intestinal Obstruction/ Perforation **HCC 34** Chronic Pancreatitis **HCC 35** Inflammatory Bowel Disease	**HCC 77** Intestine Transplant Status/Complications **HCC 78** Intestinal Obstruction/Perforation **HCC 79** Chronic Pancreatitis **HCC 80** Crohn's Disease (Regional Enteritis) **HCC 81** Ulcerative Colitis

	V24	V28
Musculoskeletal Disease Group	**HCC 39** Bone/Joint/Muscle Infections/Necrosis **HCC 40** Rheumatoid Arthritis and Inflammatory Connective Tissue Disease	**HCC 92** Bone/Joint/Muscle/Severe Soft Tissue Infections/ Necrosis **HCC 93** Rheumatoid Arthritis and Other Specified Inflammatory Rheumatic Disorders **HCC 94** Systemic Lupus Erythematosus and Other Specified Systemic Connective Tissue Disorders
Blood Disease Group	**HCC 46** Severe Hematological Disorders **HCC 47** Disorders of Immunity **HCC 48** Coagulation Defects and Other Specified Hematological Disorders	**HCC 107** Sickle Cell Anemia (Hb-SS) and Thalassemia Beta Zero **HCC 108** Sickle Cell Disorders, Except Sickle Cell Anemia (Hb-SS) and Thalassemia Beta Zero; Beta Thalassemia Major **HCC 109** Acquired Hemolytic, Aplastic, and Sideroblastic Anemias **HCC 111** Hemophilia, Male **HCC 112** Immune Thrombocytopenia and Specified Coagulation Defects and Hemorrhagic Conditions **HCC 114** Common Variable and Combined Immunodeficiencies **HCC 115** Specified Immunodeficiencies and White Blood Cell Disorders

These are just a few of the examples of the changes in models.

Patient example

Let's make this real.

You are a primary care provider treating a 70-year-old male, non-dual aged patient who has diabetes with acute complications, angina pectoris, morbid obesity, severe persistent asthma and congestive heart failure.

Just focusing on the HCC portion of the risk adjustment factor (RAF), the model differences and HCC differences are highlighted here.

As shown, the provider must code appropriately to enable the V28 HCC. Assuming this has occurred, the overall risk score increases significantly.

But what if that patient does not have asthma?

This would adjust the total risk score in V24 to be the same at **1.135**, however the V28 risk score decreases to **1.108** highlighting the importance of accurate documentation during the annual wellness visit.

V24	V28
HCC 17 Diabetes with Acute Complications **0.219**	**HCC 36** Diabetes with Severe Acute Complications **0.166**
HCC 88 Angina Pectoris **0.136**	**None**
HCC 22 Morbid Obesity **0.171**	**HCC 48** Morbid Obesity **0.186**
None	**HCC 279** Severe Persistent Asthma **0.818**
HCC 85 Congestive Heart Failure **0.251**	**HCC 224** Acute on Chronic Heart Failure **0.360**
RAF = 0.358 + 0.777 = **1.135**	RAF: 0.396 + 1.53 = **1.926**
More about V24 RAF	**More about V28 RAF**

Strategic steps for organizations

Organizations must take several strategic steps to navigate the transition from V24 to V28 effectively.

Enhancing data quality and management

Accurate and comprehensive data collection is fundamental to effective risk adjustment and investing in robust electronic health record (EHR) systems and data analytics tools will be essential.

Secondly, staff education and training are vital. Organizations should conduct comprehensive training programs to familiarize staff with the specifics of V28 and its operational implications.

Thirdly, strengthening care management programs will be essential for identifying and managing high-risk patients effectively. Organizations should focus on proactive care management to improve patient outcomes and optimize risk scores. They should also consider new, higher risk diagnosis such as the example provided above in asthma management as part of their care management programs.

Reviewing and adjusting financial strategies

Organizations need to revisit their financial plans to accommodate potential changes in revenue and costs associated with V28. This includes revising budget plans, financial forecasts, and investment strategies to align with the new risk adjustment landscape.

Engage in effective stakeholder communication

Clear communication strategies will help manage expectations and ensure all parties understand the implications of the transition to V28.

Immediate steps for organizations without a plan

Here are four immediate steps organizations should take if they do not yet have a plan in place:

Conduct a rapid data audit and impact analysis

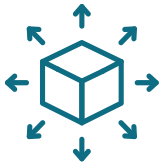
Assess the current state of your data collection and management systems to identify gaps and areas for improvement. Analyze your population data to understand the potential impact of V28 on your specific patient cohorts and financial outcomes.

Assess and educate clinical teams and coding staff

Initiate comprehensive training sessions to ensure all relevant staff, particularly those involved in clinical and coding roles, are familiar with the changes brought by V28 and its operational impacts. This will help in maintaining accurate and consistent coding practices.

Implement analytical surveillance systems

Develop and implement analytical surveillance systems to monitor the impact of V28 and track trends over time. This will enable your organization to make data-driven adjustments and respond proactively to emerging issues.



Update care management programs to address new HCCs with higher risk

Traditionally diseases such as asthma are not traditionally treated or seen within care management programs. Consider adding to your care management program offerings to address higher risk diseases now part of the RAF such as severe asthma.

To navigate the complexities of the V24 to V28 transition effectively, consider engaging MedeAnalytics consultants.

Our strategic advisory experts can conduct a rapid assessment and help build a comprehensive plan to ensure your organization is prepared for the new risk adjustment landscape.

Contact us today to schedule your consultation and secure your path to compliance and optimization under the new CMS-HCC model.

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