

Mastering the CMS v28 Transition: Navigating Risk Adjustment Changes and Revenue Impacts

Presented By:

Lynne Padilla | *Head of Coding Solutions* | **Datavant**

Brian Jones | *Data Analyst, Risk Adjustment, Payer Solutions* | **Datavant**



Webinar Participant Tips

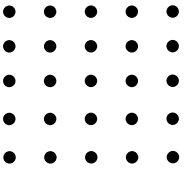
- All participant lines are muted. To protect your privacy, you will only see your name and the presenters names in the participant box.
 - To submit a question to the presenters any time during the event:
 - In the Event window, in the Panels drop-down list, select Q & A.
 - Type your question in the Q & A box.
 - Click "Send".

Disclaimer

The information provided in this webinar does not, and is not intended to, constitute legal advice; instead, all information, content, and materials available in this webinar are for general informational purposes only. Information in this webinar may not constitute the most up-to-date legal or other information.

The webinar and slide show contain links to other third-party websites. Such links are only for the convenience of the reader or user; Datavant (formerly known as Ciox Health) does not recommend or endorse the contents of the third-party sites.

Meet the Presenters



Lynne Padilla

Head of Coding Solutions

Datavant



Brian Jones

Payer Product

Datavant

Bio(s)

datavant

Lynne Padilla serves as the driving force behind payer coding at Datavant. With over two decades spent in healthcare, Lynne consistently seeks to bridge the gap between accurate and complete coding data and healthcare, ultimately contributing to the betterment of patient care and the healthcare ecosystem as a whole. Prior to Datavant, Lynne led product and coding operations for Optum/Change Healthcare.

Brian Jones has over a decade of experience in healthcare analytics, specializing in risk adjustment and payer data solutions. His career includes solution development and leadership roles both within health plans and risk adjustment vendors. With an upbringing in an actuarial department, Brian focuses on delivering data-driven solutions that produce credible and measurable results across the healthcare ecosystem.

Agenda

Today, we will cover the following:

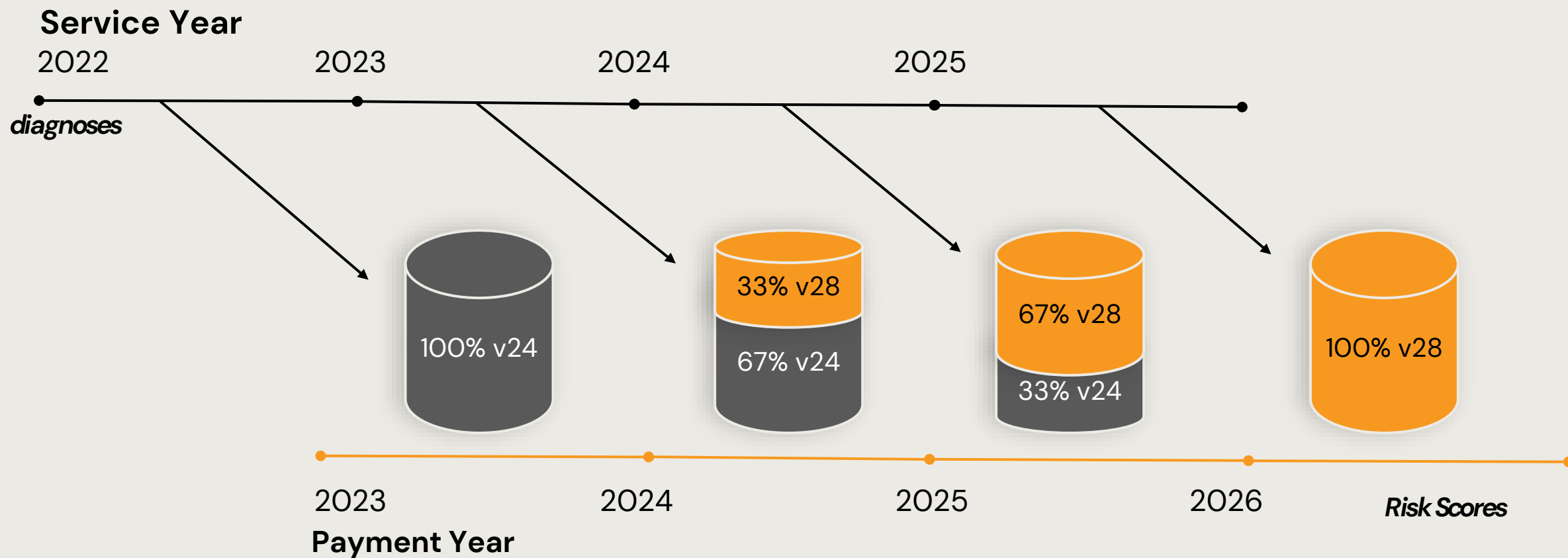
- v28 Introduction & Overview
- Impact Analysis Case Study
- Clinical & Coding Examples
- Recommendations & Strategies for Success
- Q&A

By the end of this session, you will understand the implementation timeline and key changes of the v28 model, the potential impact it may have on your organization and have an idea of what strategies and organizational areas need to be prioritized to ensure your risk adjustment programs are optimized.

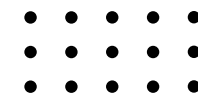
Mastering the CMS v28 Transition: Navigating Risk Adjustment Changes and Revenue Impacts



Transition Timeline: v24 to v28



CMS v28 Model: Key Changes And Impacts



Key v28 Model Updates



Model calibration changes from ICD-9 to ICD-10



Increasing the number of HCCs in the v28 model from 86 to 115



Removal of >2,000 diagnosis codes that no longer map to HCCs in the v28 model



Changes to name and numbering of v28 HCC codes



Updates underlying FFS data years from 2014 diagnoses and 2015 expenditures to 2018 diagnoses and 2019 expenditures



Changes to the HCC coefficient values

Additional Changes in v28

Constrained Conditions:

Equal coefficients applied to all diabetic and congestive heart failure conditions

HCCs dropped entirely:

Protein-calorie malnutrition, angina pectoris, dialysis status, acute renal failure, complications of implanted devices or grafts

Prevalent diagnoses dropped:

Including; Vascular disease, unspecified acute kidney failure, coagulation defects

Conditions Excluded in v28

Understanding What's Removed

Most prevalent categories excluded in v28:

Vascular Disease

Angina Pectoris

Acute Renal Failure

Protein-Calorie Malnutrition

Examples below:

ICD	I70.0 Atherosclerosis of aorta	G319 Degenerative disease of nervous system, unspecified	M461 Sacroiliitis, not elsewhere classified
v24	108 Vascular Disease	52 Dementia Without Complication	40 Rheumatoid Arthritis and Inflammatory Connective Tissue Disease
v28	Not risk adjustable In all cases, a more specific diagnosis code would risk adjust if it exists – the opportunity to capture these conditions hangs on the providers coding to the correct level of specificity, when appropriate		

Key Reasons for Exclusions:

- Conditions that didn't accurately predict marginal costs (subsequent encounters and sequelae)
 - Condition coefficients that were inconsequentially small.
 - Uncommon conditions or those with poorly defined diagnostic coding criteria.
- Conditions with a high observed discretionary coding pattern when comparing FFS data to MA data
 - Reclassification of conditions to more appropriately align with ICD-10 coding practices

New v28 Conditions

268 ICD codes were added to the v28 model, of which over 40% are not prevalent in the Medicare population.

The v28 model calibration to align with ICD-10 includes new diagnoses to assist in capturing conditions at a more granular and specific level than before, with many HCC categories being split into more detailed sub-categories (like the Lung disease group going from 5 HCCs to 7)

Anorexia Nervosa



Anorexia Nervosa is an eating disorder characterized by an abnormally low body weight, an intense fear of gaining weight, and a distorted perception of body weight.

- Reiterate consulting physician's specific diagnoses and/or continuing treatment plan for the patient's condition in documentation

Benign Carcinoid Tumors



Benign carcinoid tumors are slow-growing tumors that originate from neuroendocrine cells found particularly in the GI tract, lungs and pancreas.

- These tumors have a better prognosis compared to more aggressive forms of neuroendocrine tumors
- Documentation of positive benign biopsy results and continued medical therapy are key in supporting the condition as current

Severe Persistent Asthma



Severe Persistent Asthma is a type of asthma that requires daily medication and frequent medical attention.

- Asthma – Severe Persistent Asthma is the only risk adjustable asthma in v28
- Documentation of this specificity when present in a patient is critical to reporting

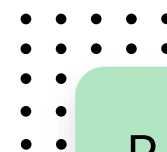
Presence of Artificial Legs



Presence of Artificial Leg(s) refers to the use of prosthetic limbs to replace a missing or damaged limb.

- Amputation status of the toes has been removed in the v28 model, as well as sequela and subsequent encounter for traumatic amputations
- Presence of Artificial limb has been added. Noting an artificial limb should be included in documentation

Patient Examples



RAF Increase

Clinical Example: Impact of v24 to v28

Patient Example No. 1

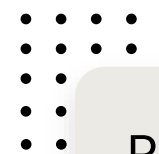


Patient

Community, non-dual, male age 88

Diagnoses and conditions: Type 1 DM without complications, Alzheimer's disease, and persistent asthma.

Category	v24		v28		
	HCC	RAF	HCC	RAF	
Demographic	M80-89	0.686	M80-89	0.664	
E109 - Type 1 DM w/o Compl	19	0.105	38	0.166	
G309 - Alzheimer's Disease	52	0.346	127	0.341	
J4550 - Severe persistent Asthma	-	0.000	279	0.818	
Payment Condition Count	2	0.000	3	0.000	
Total		1.137		1.989	
PY2025 Adjusted Risk Score (Norm/C.I.)		0.928		1.791	93%
Financial Estimate (\$1,000 PMPM per 1.0)		\$11,136		\$21,492	\$10,356



RAF Decrease

Clinical Example: Impact of v24 to v28

Patient Example No. 2



Patient

Community, non-dual, female age 65

Diagnoses and conditions: Type 2 DM with foot ulcer, PVD, dilated cardiomyopathy, and protein-calorie malnutrition

Category	v24		v28	
	HCC	RAF	HCC	RAF
Demographic	F65-69	0.323	F65-69	0.330
E11621 - Type 2 DM w/ foot ulcer	18	0.302	37	0.166
	161	0.515	383	0.646
I739 - Peripheral vascular disease, unsp	108	0.288	-	0.000
I420 - Dilated cardiomyopathy	85	0.331	227	0.189
E441 - Mild protein-calorie malnutrition	21	0.455	-	0.000
Payment Condition Count	5	0.042	3	0.000
Diabetes-CHF Interaction	-	0.121	-	0.000
Total		2.377		1.331
PY2025 Adjusted Risk Score (Norm/C.I.)		1.94		1.199
Financial Estimate (\$1,000 PMPM per 1.0)		\$23,280		\$14,388
				-38%
				(\$8,892)

Recommendations & Strategies for Success



Where to Focus for Success



**Double-down on
Education & Training**



**Leverage Tech, Data &
AI-Based Tools**



**Ensure operations and
platforms are kept up-
to-date**

10-Item Checklist for v28 Readiness

1. Double Down on Education

Equip health plans and providers with targeted training on v28 implications, including coding and documentation.

2. Leverage the Part D Model

Close gaps and ensure coding of Part D diagnosis codes. Don't overlook the importance of the Part D model.

3. Collaborate with Data Science Teams

Validate that coding platforms, AI, and NLP models are updated to reflect v28 changes. Confirm correct models are being used for suspecting and analytics.

4. Streamline Dual Models

Manage v24 and v28 dual models effectively to minimize complexity during the transition.

5. Focus on Specificity

Train providers to document with precision, addressing common gaps such as unspecified chronic conditions and missing severity details. (Mild, Moderate, Severe, Acute, Chronic, Persistent)

6. Incorporate v28 into Coding Guidelines

Ensure coding staff is well-versed in v28 guidelines for better risk adjustment accuracy & completeness.

7. Monitor Population Impact

Analyze the population impact differences between v24 and v28 to guide strategic decisions.

8. Ensure Accurate Data Capture

Capture high-risk focus areas like metabolic disorders and ensure complete documentation before claims submission.

9. Implement Real-Time Dashboards

Use dashboards to monitor coding accuracy and RAF scores in real time.

10. Provide Ongoing Education

Continuously refine processes as CMS fully transitions to v28 and provide additional training as needed.

Thank you

datavant

Questions?



Lynne Padilla

lynne.padilla@datavant.com

Brian Jones

brian.jones@datavant.com



RISE