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CMS-HCCs V28 Survival Guide

From V24 to V28 — A Smarter Risk Adjustment Guide to Navigating Change with Confidence

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LETTER FROM JASON JOBES

Surviving (and Thriving) in V28 of CMS-HCCs

The 2026 Medicare Advantage and Part D Final Notice released in April affirmed that V28 of CMS-HCCs will be fully implemented in 2026. Per CMS: "CMS is completing the phase-in of the 2024 CMS-HCC model as proposed in the CY 2026 Advance Notice by using 100 percent of the risk score calculated using the 2024 CMS-HCC risk adjustment model."

For many folks anxiously looking for confirmation that V28 will be fully implemented starting Jan. 1, 2026, this is it.

The implementation of V28 is, without exaggeration, a seismic event in healthcare. In fact, we're already seeing its considerable impact—and it hasn't been fully implemented. Here's a couple examples.

In a bankruptcy announcement, Clinical Care Medical Centers said the "most significant headwind" was related to the Medicare risk-adjustment model implemented by CMS.

In a financial results statement, UnitedHealth Care (UHC) said its 2024 full year medical loss ratio (MLR) was 85.5%, compared to 83.2% in 2023. That 2.3 percentage point increase is nearly the same percent as the V28 impact in 2024. In fact, United said "the increase was primarily due to previously discussed items, including the revenue effects of CMS's Medicare funding reductions."

I noted that V28 would impact UHC the most because of its massive market share. But the numbers are staggering: This increase in medical loss ratio effectively removed $9B from UHC's bottom line. That means less profit for them (which some will celebrate), but it also means less for patient care and less compensation for providers. I would expect renewed pressure to cut claims expenses, too.

Initial projections have shown that the total impact would be approximately $11B in funding. That is a lot of care, about what CMS would spend on 1 million Medicare beneficiaries. Basically that is 1 in every 33 MA beneficiaries, or a 3% decrease in revenue.

Your best defense in this new environment of reduced compensation and tightened utilization is sound strategy and an effective offense. Knowing which conditions risk adjust (and which don't). Getting patients scheduled efficiently, and all relevant conditions captured compliantly.

Consider this *CMS-HCC V28 Survival Guide* your blueprint for 2026 readiness. And know that Norwood is here to help and see you through to the other side.

All the best,

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V28 Survival Guide

Understand Financial Impact

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STEP 1

Assess Your Organization's Financial Impact from the V28 Shift

How closely have you examined your organization's financial impact from the shift to V28 of CMS-HCCs? Do you know the impact and the diagnosis codes driving the change? Are you doing anything about it?

High-performing organizations are the ones that recognize the impact, while low-performing organizations have yet to assess where they stand.

At a recent conference, I gave a presentation assessing the projected impact for one organization. The impact is significant. The graphic below shows the decrease in the percentage of patients within each clinical condition category.

For example, if the organization documented the same condition previously captured under vascular disease, they would now lose risk score credit for 92% of those patients.

This shift is due to conditions that previously mapped to a risk adjustment category no longer mapping under the revised model.

In total the impact is nearly $13M of decreased care funding.

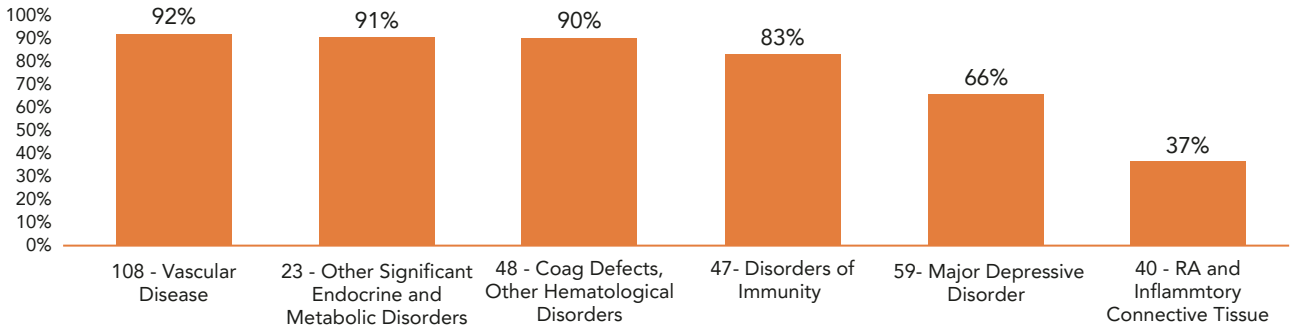
Many organizations use recapture rate to gauge current-year performance. However, with the model change, recapture rate alone doesn't tell the full story.

You must understand which specific diagnosis codes still risk adjust—and which are no longer included under V28.

The strategy is no different than knowing how diagnosis codes change in mapping to CCs or MCCs.

Prevalence Rate Decrease by V24 HCC

Sample Organization - Based on Calendar Year 2024 Visits



$12.6M Disease

The impact for the organization alone, if not for CDI and provider education, would nearly be $13M annually.

Here are three recommendations:

Know Your Performance Data

Information is the foundation of performance success. I've encountered several organizations recently that either wait for payers to provide performance data or don't know where to begin.

If you're billing for care, then you already have a starting point. Leverage your internal claims and coding data to gain visibility into your performance.

Assess the Impact

It's not enough to just know your data—you need to apply the V28 models to understand the financial and operational impact on your organization. Evaluate changes across HCC categories, diagnosis codes, and down to the individual provider level.

This detailed analysis will help you build a targeted mitigation strategy and inform your education efforts organization-wide.

Leverage Your Outpatient CDI and Provider Education Teams

There are diagnosis codes that still risk adjust within categories most affected by the changes.

Has there been a shift in clinical status that now calls for a different diagnosis or greater specificity? Your CDI and education teams are key to driving accurate documentation and supporting sustainable change.

STEP 2

Understand Which Conditions No Longer Risk Adjust in V28

CMS V28 Payment Model

Conditions Completely Removed from the Model

Description Label	Diagnoses That Mapped to HCC	2023 Weight	Estimated Patients with Condition per 10K Lives	Estimated Impact per 10K Lives
21 - Protein Calorie Malnutrition	10	0.455	226	$1,1018,017
88 - Angina Pectoris	36	0.135	415	$553,648
134 - Dialysis Status*	50	0.435	21	$90,437
135 - Acute Renal Failure*	5	0.435	467	$2,011,136
176 - Complications of Specified Implanted Device or Graft	325	0.582	131	$754,796

$4.4M per 10,000 Lives

Removal of these conditions will have a noticeable impact on overall care funding. The removal of these conditions from the model allows for weights to be shifted elsewhere, but also contributes to the expected fall in risk scores.

*Impact doesn't account for underlying condition if condition trumped another category.

What CMS is quietly signaling in V28: Payment is shifting away from potentially avoidable outcomes. Here's what that means—and why it matters.

Even for smaller organizations in Medicare risk arrangements, the removal of conditions that no longer risk adjust under V28 can carry significant financial consequences. That's why it's critical to understand which conditions are being phased out—and why.

The more I reflect on the removed conditions, the more I see a potential theme behind CMS's decisions.

Let's take a closer look. These conditions were risk adjustable for 2024 dates of service (with payment in 2025), but after the three-year phase-out will no longer risk adjust.

According to the final 2024 Payment Rule, CMS Fully Removed Five (5) HCC Categories which previously encompassed 426 unique diagnoses.

These include:

1. Malnutrition
2. Angina (unstable angina remains risk adjustable)
3. Dialysis Status
4. Acute Renal Failure (CKD remains in the model)
5. Complications of specified Implanted Devices or Grafts

Getting back to the why—as a non-clinician, I find these choices particularly interesting. From my perspective, they all seem to follow a common theme: **conditions that may be preventable.**

Yes, most clinical conditions can be mitigated to some extent with better health, but hear me out.

Could CMS be expanding on the principle of not paying for potentially avoidable outcomes?

And if so, what might that mean for future payment models?

I'll save a deeper dive for another report—but here's what we're seeing:

Malnutrition

From a non-clinical perspective, I think about food availability. This could also be addressed by increasing caloric intake. I recognize the opposite can be true—yet morbid obesity remains in the model. Is CMS tying this to Social Determinants of Health (SDOH) in a fascinating way?

Angina

Admittedly, this is one I'll leave to the clinical experts—but can't this condition often be stabilized?

Dialysis Status and Acute Renal Failure

While the model still includes CKD, this appears to reflect a shift away from reimbursing for acute exacerbations or dialysis-related complications.

Complications of Implant

This category had 325 eliminated codes. Is CMS signaling that it no longer intends to pay for complications?

CMS V28 Payment Model

Diabetes Coeffecients by Hierarchical Condition

HCC	Description Label	Community, Non Dual, Aged	Community, Non Dual, Disabled	Community, FB Dual, Aged	Community, FB Dual, Disabled	Community, PB Dual, Aged	Community, PB Dual, Disabled	Institutional
HCC 36	Diabetes with Severe Acute Complications	0.166	0.191	0.186	0.235	0.166	0.21	0.28
HCC 37	Diabetes with Chronic Complications	0.166	0.191	0.186	0.235	0.166	0.21	0.28
HCC 38	Diabetes with Glycemic, Unspecified or No Complications	0.166	0.191	0.186	0.235	0.166	0.21	0.28

Condition coefficients are for the Diabetic HCC are identical within each population bucket

What About Diabetes?
Diabetes remains in the model, but the changes are notable. First, the HCC numbers we've long known are shifting—HCCs 17–19 will become HCCs 36–38. And more importantly, the total number of risk-adjusting diabetes diagnoses dropped from 429 to 343, with every removed code tied to drug- or chemically induced diabetes. That part seems straightforward.

What's surprising is this: All diabetic HCCs now carry the exact same weight (coefficient). That means a patient with serious complications is scored the same as one without. Trumping logic still applies, but there's no difference in risk score between complex and uncomplicated cases.

In short: **CMS appears to be** shifting more responsibility to organizations by **pulling back payment for poor or preventable outcomes.**

We see this not just in the diabetes adjustments, but also in how subsequent and sequelae events tied to depression have been deprioritized.

There's still logic in how disease progression is modeled—but my gut says CMS is sending a clear message to payers:

We're not going to keep subsidizing poor outcomes.

Is this a sign of broader policy change–or just a coincidence?

Time will tell.

STEP 3

Understand New Conditions with V28 Impact

V28 is not all gloom-and-doom. The new model has introduced several notable ICD-10-CM codes that now map to HCCs. These are available in an excel file on the CMS website.

I thought I'd share a few that stand out to me, from my non-clinical perspective. Previously, these diagnoses did not map to any HCC in V24.

Bulimia Nervosa (F502)

Interesting that unspecified or mild forms of bulimia fall into the same HCC (153) as severe or extreme. Bulimia nervosa in remission (F5025) also holds weight.

Alcoholic Hepatitis (K7010-K7011)

Both with and without ascites, alcoholic hepatitis has been added to the HCC list, acknowledging the toll it plays with increased healthcare utilization and mortality risk.

Malignant Pleural Effusion (J910)

Obstruction of the Bile Duct (K831)

Severe Persistent Asthma and its subtypes (J4550-J4552).

Of course this makes sense, but notable that unspecified asthma, even with acute exacerbation (J45901) holds no weight in V28. Which means providers must specify type.

Toxic Liver Disease with Chronic Persistent Hepatitis (K713) and various subtypes (K714, K7150, K7151, K717)

These conditions underscore the importance of capturing liver-related diseases in risk assessments.

It probably goes without saying (but I'll say it anyway): knowing which conditions are new to the model is only part of the work.

CDI and coding professionals must take the lead in educating providers to document these conditions with specificity.

That means

- **ensuring assistive code capture tools are updated**
- **reviewing and maintaining problem lists**
- **properly training coding staff**

There's also much more detail to analyze in this file. For instance, under V24, dementia was classified in just two buckets—with complications (HCC 51) and without (HCC 52).

V28, however, breaks it down further:

- **severe (125)**
- **moderate (126),**
- **mild or unspecified (127).**

Interestingly, all three share the same RAF score (0.341), despite the additional stratification.

Of course, all nonspecific, conflicting, incomplete, ambiguous, or inconsistent documentation should be clarified, regardless of financial impact.

Still, knowing what officially counts toward risk adjustment gives you a focused direction for documentation and education efforts.

And one last thing—CMS's website isn't exactly user-friendly (as anyone who's tried will tell you). So to save you time, I've included a direct link to the 2025 Model Software/ICD-10 Mappings.

Reference: CMS.gov
https://www.cms.gov/medicare/payment/medicare-advantage-rates-statistics/risk-adjustment/2025-model-software/icd-10-mappings

STEP 4

Understand Conditions with The Largest Care Funding Increase

CMS V28 Payment Model

Conditions with largest care funding increase

Description Label	V24 HCC	V28 HCC	2023 Weight	2024 Weight	Percentage Change	Estimated Patients with Conditions per 10K Lives	Estimated Impact per 10K Lives
CKD, Severe (Stage 4)	137	327	0.289	0.514	78%	100	**$222,750**
Multiple Sclerosis	77	198	0.423	0.647	53%	58	**$128,621**
Intestinal Obstruction/ Perforation	33	78	0.219	0.326	49%	111	**$117,582**
Artificial Openings for Feeding or Elimination	188	463	0.534	0.673	26%	85	**$116, 969**
Exudative Macular Degeneration	124	300	0.521	0.596	14%	142	**$105,435**

$691K per 10,000 Lives

While these conditions are all seen infrequently (<1.5% of patients), the significance of the weight changes means these could have a disproportionate impact on funding.

*Care funding assumes a $9,900 PMPY funding for a 1.00 risk adjustment factor patient.

Did you know some CMS-HCCs actually increased in value under the new model?

Have you placed additional focus on them? Some organizations are already making strategic moves to maximize that benefit.

I want to highlight what I think is an interesting trend in the 2024 CMS Final Rule—a series of HCC weight increases. First, 34 of the original 86 HCCs remained largely unchanged in terms of diagnosis mapping.

In other words, all of the diagnoses in a given HCC (e.g., HIV/AIDS) carried over identically to their new, often renumbered, counterparts. Ahh, consistency.

But here's where it gets interesting:

21 of those 34 categories will carry a higher relative weight in V28.

Quick Reminder:

Payment Year 2024 = diagnoses captured in 2023
Payment Year 2025 = diagnoses captured in 2024
Payment Year 2026 = diagnoses captured in 2025

So, accurate and complete recapture of these conditions directly translates to increased care funding.

However, not all of these are chronic conditions. Some, like intestinal perforation or obstruction, may not be expected to recur annually—so not everything here is meant to be chased every year.

I combined prevalence data with an estimated per-member-per-month premium and ran some projections. Assuming prevalence and recapture are consistent, five conditions in particular show meaningful increases in relative weight. The potential return?

~$700,000 in additional Care Funding per 10,000 lives.

Of course, how much of that your organization captures depends on your specific Medicare risk arrangements.

So, have you shifted focus toward these high-impact conditions?

Have you adjusted any of your suspecting logic or algorithms to boost net-new identification?

Those are survival strategies I'd strongly recommend considering.

Let's dive into them next.

Reference: Medicare Advantage Final Rule

Contract Year 2026 Policy and Technical Changes to the Medicare Advantage Program, Medicare Prescription Drug Benefit Program, Medicare Cost Plan Program, and Programs of All-Inclusive Care for the Elderly (CMS-4208-F): https://www.cms.gov/newsroom/fact-sheets/contract-year-2026-policy-and-technical-changes-medicare-advantage-program-medicare-prescription-final

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Implement Survival Strategies

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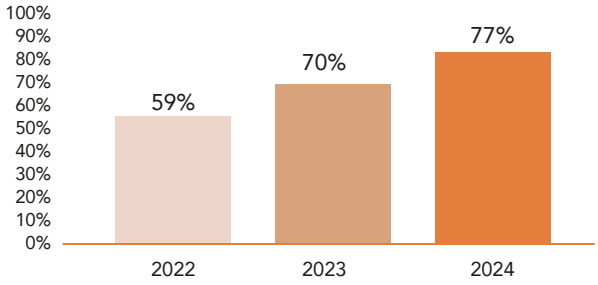
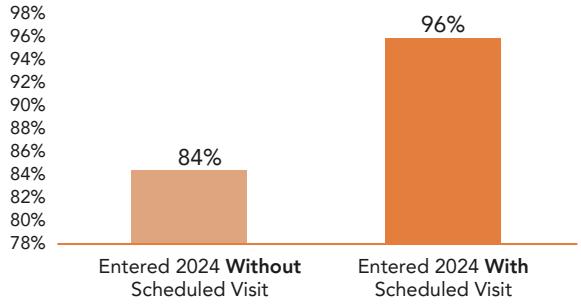
BEST PRACTICE TIP 1:
Rigorously Schedule Patients

Tips for Risk Adjustment Success – Scheduling Patients

Standardizing patient scheduling and booking patients for follow-up visits is a key driver of Risk Adjustment Success. Here is what one organization did to drive Risk Score Accuracy



Year End Patient Scheduling Rates
Calendar Years 2022-2024



Percent of Chronic Conditions Captured
2024 Patients Based on Prior Year Scheduling

As full implementation of V28 of CMS-HCCs hits home, I want to share a best practice I discuss with our partners: On January 1st of every year identify what percentage of your patients' risk-based contracts have a scheduled PCP appointment.

Specifically, I like to ask our partners: What percentage of your patients have their next visit scheduled when they leave their current office visit? The number often surprises me.

Here is a look at one of our partners' performance (see graphic above). In 2022 we discussed improving the scheduling process for the patients that they have in risk-based contracts. The idea was that healthy patients should at least have an annual wellness visit or physical scheduled, and those with chronic conditions should have follow-up visits.

This organization over the last two years made some solid strides in improving the check-out process and scheduling patients for their next visit. In 2024 we looked at the percent of the known chronic conditions that were captured for those who entered 1/1/2024 with a visit scheduled vs those that didn't.

The patients with visits that were on the books by Jan. 1 drastically outperformed those who didn't.

So, how does your organization do? Are you even focusing on what percent of patients have appointments? How are you focusing on the other processes besides just documentation to drive risk success?

For 2026—year one of V28—I recommend on the first day of the year you run a report of the patients in your risk pool and if they have a visit scheduled with their PCP. Track performance across the year and track the outcomes.

Some organizations wait to do this until the last quarter of the year. I recently had a great conversation with an organization who does incredibly well on that in Q4. I asked them why they waited.

They said because there were outstanding gaps and the patients hadn't been seen that year. I applauded their efforts … and then asked how they were ensuring the patients received continuous care for their chronic conditions throughout the year. The silence was deafening.

If you need help with your risk program or want to hear more about any of the other 45 best practices we have on hand, let's talk.

BEST PRACTICE TIP 2:
Submit Clean, Accurate, Full Claims Up Front

How much money are you leaving on the table if even the Office of Inspector General (OIG) is finding 21 additional HCCs per 100 patients reviewed?

That's notable—because the OIG is usually known for identifying overcaptured conditions. But in their random audits, they're also finding valid, compliant, underreported CMS-HCCs.

If the OIG is uncovering missed HCCs, there's a strong chance your organization is too. And that's why this is our V28 Best Practice Tip #2. Let's dig in.

The OIG historically conducts two types of Retrospective Reviews:

Targeted Reviews

Focused on high-risk diagnosis codes frequently captured in error. These often involve acute conditions such as cancer, stroke, or heart attacks that may be carried over incorrectly from one year to the next.

Random Reviews

Reviews of 200 patients to evaluate the totality of the medical record. In random reviews the OIG looks for both conditions over captured, as well as those that may have been missed in the submission process.

If the OIG is detecting compliant yet unsubmitted HCCs in a random sample, you can assume similar gaps exist in your own data. The opportunity for improvement—and additional funding—is there.

My review of every random audit published by the OIG over the last three years reveals a consistent pattern: Medicare Advantage plans are failing to submit valid, supported conditions—leaving money on the table.

Yes, the OIG often finds a higher volume of unsupported diagnoses that were inappropriately submitted. But what's often overlooked is that these reviews also uncover missed opportunities—valid conditions that were documented but never submitted for payment. That points to a need for more robust supplemental review processes at both the provider and plan level.

Across seven audits totaling 1,400 patients, the OIG found 302 supported conditions that were not submitted. That's nearly 22 missed conditions per 100 patients—equating to approximately $427 per patient in missed risk-adjusted payment.

The graph below breaks this down by Medicare contract number, showing how many supported conditions per 100 patients went unsubmitted.

Now, before anyone runs out saying, "We should be getting $427 more per patient!"—let's add some context.

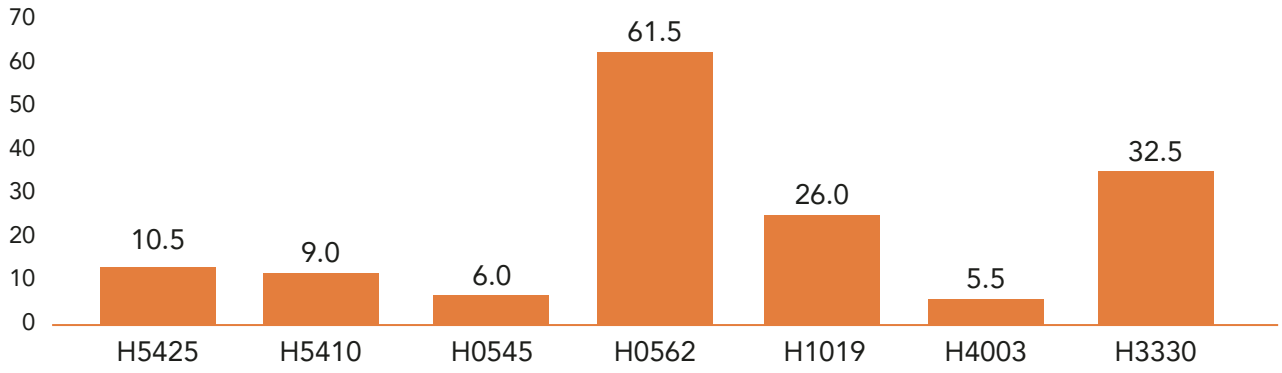
You shouldn't extrapolate this figure across your entire population. The OIG often reviews complex, high-risk patients, which likely inflates the per-patient average. Still, underreporting is real—and even if the missed opportunity is just $42 per patient, an attributed population of 25,000 lives would translate to over $1 million in unfunded premiums.

Missed HCCs Identified in OIG Reviews

The OIG publishes details from every report including the count of HCCs reviewed, validated, changed, or added. Performance will vary by review but overall findings show Medicare Advantage payers sometimes missed submitting valid HCCs for risk score consideration

OIG Added HCCs per 100 Patients Reviewed

*OIG Random Reviews 2022-2024 (**Note**: H values are Medicare contract ID's)*



21.6

Number of HCCs per 100 patients reviewed that were found as documented but not submitted

Three strategies to consider in your pursuit to a complete and accurate risk score:

1. **Conduct thorough retrospective reviews**
   Identify conditions that were documented but never submitted—and remove unsupported ones at the same time.
2. **Reconcile claims submissions with CMS or payer data**
   Ensure you're capturing what was actually accepted and flag any potential data leakage or submission gaps.
3. **Leverage a strong outpatient CDI program**
   Partner with your population health team to proactively alert clinicians to conditions that need to be addressed during patient visits.

BEST PRACTICE TIP 3:
Submit (and Remove) Conditions During Supplemental Diagnosis Window

Medicare Advantage (MA) plans can more accurately reflect the chronic disease burden of their populations by submitting supplemental diagnoses.

This process enables plans to capture valid conditions that were not originally reported on claims—and remove diagnoses that are invalid or lack supporting documentation.

The Supplemental Diagnosis Submission Process allows Medicare Advantage Organizations (MAOs) to submit additional or corrected diagnosis codes to CMS for risk adjustment purposes. It ensures that a member's health status is accurately reflected, leading to more appropriate risk scores and reimbursement.

However, submitting supplemental diagnoses compliantly and on time can be challenging. Submissions must be completed before CMS' final risk adjustment deadline for the applicable payment year—typically January of the following year (e.g., January 2025 for 2024 dates of service).

While CMS allows multiple submission windows throughout the year, there is a final reconciliation deadline, and submissions must follow CMS' standardized format. Importantly, this process applies only to Medicare Advantage, not traditional Medicare.

A Real-World Example
In 2023, one health plan struggled to meet the supplemental diagnosis submission deadline and turned to Norwood for support.

Our team of CDI, coding, and risk adjustment experts partnered with the plan to conduct a retrospective review of conditions tied to 2023 dates of service. The focus was on suspect conditions with a high likelihood of clinical validity —confirmed by the presence of MEAT criteria (i.e., whether the condition was Monitored, Evaluated, Assessed, or Treated by a provider).

Our Work

- 692 individual conditions were reviewed
- 163 conditions were identified as likely to exist
- 24 conditions were added after cross-referencing eligibility

The Results

- 24 conditions of the 692 were added
- The health plan submitted these in the supplemental submission process
- Over $200k of opportunity was identified vs. $16k of investment.

We hope you might consider Norwood as your partner, but you can do the work yourself.

In fact, it must be done to survive under V28.

BONUS TIP:
Be Wary of Single-time HCC Submissions

In risk adjustment, submitting a diagnosis only once per year may technically meet inclusion criteria—but it also creates a major vulnerability. Regulatory bodies like the Office of Inspector General (OIG) need only refute one date of service to classify a condition as unsupported for risk scoring. That means single-time HCC submissions are high-risk and often trigger scrutiny during audits.

Here's how to mitigate that risk and strengthen your documentation and coding practices:

Run Reports to Identify Single-Time Submissions

Start by generating internal reports of all submitted diagnosis codes tied to eligible CPT codes. Flag conditions captured only once during the calendar year. Alternatively, request reports from your payers that identify single-time HCC captures among your attributed population.

Prioritize High-Risk Conditions for Review

Not all single-time submissions pose the same level of risk. Focus first on:

- High-risk conditions identified by the OIG
- Newly captured conditions not previously documented
- Acute conditions historically documented in outpatient or office settings

These categories are more likely to be challenged during an audit and should be reviewed proactively.

Collaborate with Payers

Single-time HCCs often result from fragmented care—captured by multiple providers or across care settings. If your internal data shows only one instance of documentation, coordinate with your payers to confirm whether the condition was recorded elsewhere. If not, consider submitting a supplemental file to remove unsupported diagnoses or add missing ones.

Ignoring single-time HCCs introduces real compliance risk. An unsupported diagnosis can lead to overpayments, financial penalties, and reputational damage. But proactively identifying and resolving these gaps not only protects your organization—it reinforces your commitment to accuracy, compliance, and high-quality care.

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- Clinical Documentation Integrity
- HCC Auditors and Coders
- Trauma Registry Professionals
- Oncology Registry Professionals
- Department Leadership

CDI

Inpatient | Outpatient

Pediatric CDI

Chart Reviews & Compliance

CDI Program Implementations

Inpatient | Outpatient

Data Analysis

Payer Partnerships

Denials Management

Supplemental Diagnosis Submissions

Coding Audits

- CPT
- E/M
- HCPCS
- ICD-10-CM
- ICD-10-PCS
- HCC

MS-DRG

Optimization & Compliance

Managed Services

Outsourced Revenue Cycle Management

Risk Adjustment Factor (RAF)

Optimization & Compliance

Education

Live and Remote/Online

- CDI
- Coding
- Providers
- Outpatient CDI Boot Camp

If you don't see something here, ask. We're all about customization. You wouldn't expect to pluck an EHR off the shelf and use it. We feel the same about our solutions.

What Makes Us Different?

FLEXIBILITY

Whether implementing an outpatient CDI program, staffing your department, or auditing charts, we deliver flexibility with exceptional performance.

PEOPLE

We offer big-corporation resources with a small-company feel—Norwood is privately owned, independent, and values-driven.