VALUE-BASED CARE FOR BEYOND 2025

CHARLES JAMES: NORTH AMERICAN HMS/ RURAL ADVANTAGE ACO

6.5.2025

“I was just there.”

IT IS TIME FOR PRIMARY CARE TO EVOLVE.

VALUE BASED PAYMENTS (VBP)

- ✓ Quality Payment Programs
- ✓ Spectrum of Risk
- ✓ Medicare Shared Savings/Accountable Care Organizations
- ✓ HEDIS - CAHPS
- ✓ Medicare Advantage
- ✓ Care Gaps: Value Based Dollars Now!!
- ✓ HCC Coding and Risk

WHAT ARE VALUE-BASED PAYMENT PROGRAMS?

According to the Centers for Medicare and Medicaid Services (CMS):

“Value-based programs reward health care providers with incentive payments for the quality of care they give to people with Medicare. These programs are part of our larger quality strategy to reform how health care is delivered and paid for”

“What are Value Based Payment Programs”. https://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/Value-Based-Programs/Value-Based-Programs. Centers for Medicare and Medicaid Services. Page Last Modified: 03/31/2022. Accessed 5.23.2023.

CMS QUALITY PAYMENT PROGRAM

1. Support care improvement by focusing on better outcomes for patients, decreased provider burden, and preservation of independent clinical practice;
2. Promote adoption of Alternative Payment Models that align incentives across healthcare stakeholders; and
3. Advance existing efforts of Delivery System Reform, including ensuring a smooth transition to a new system that promotes high-quality, efficient care through unification of CMS legacy programs.

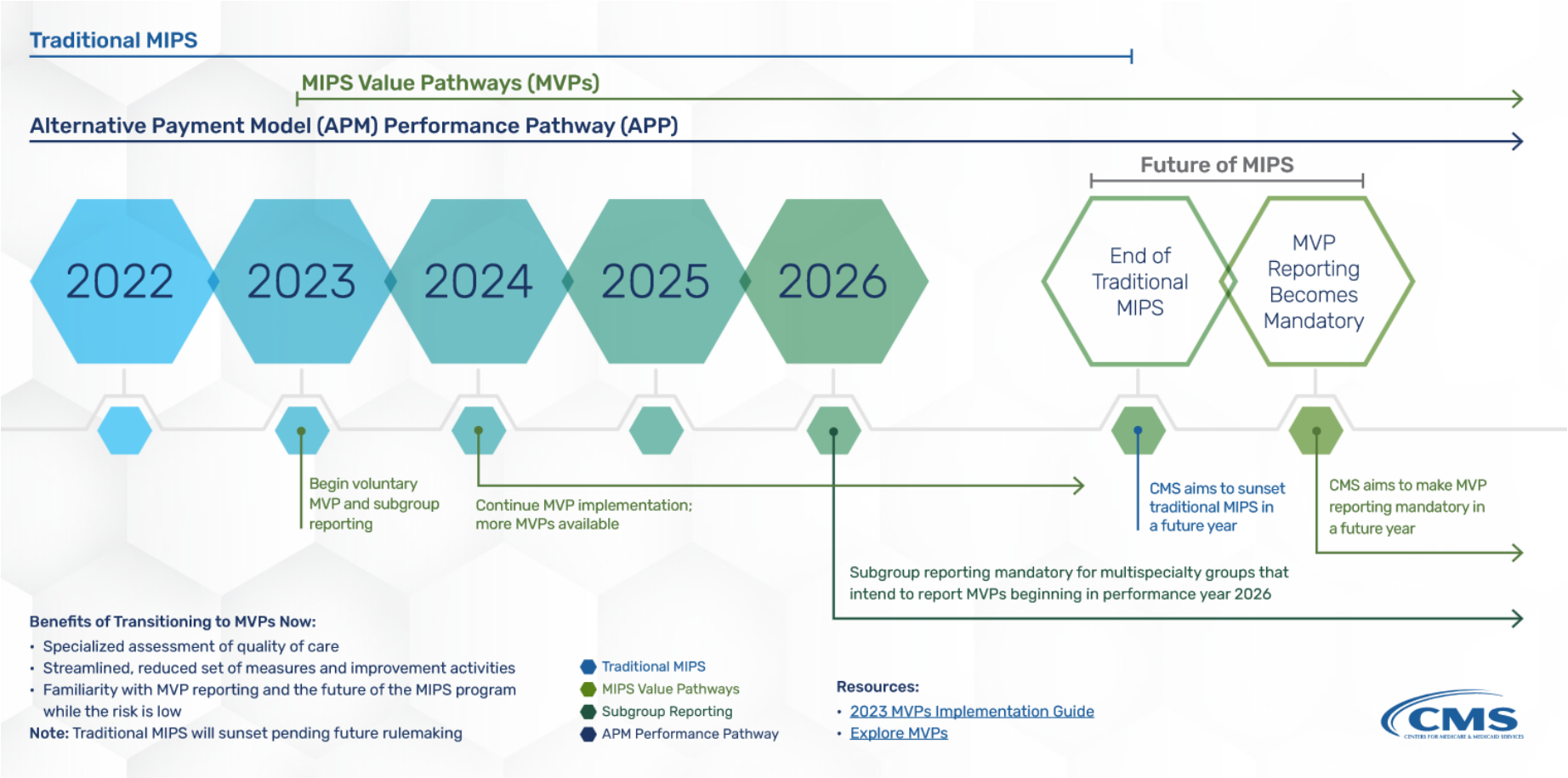
(CMS MIPS Final Rule)

MEDICARE QUALITY PAYMENTS

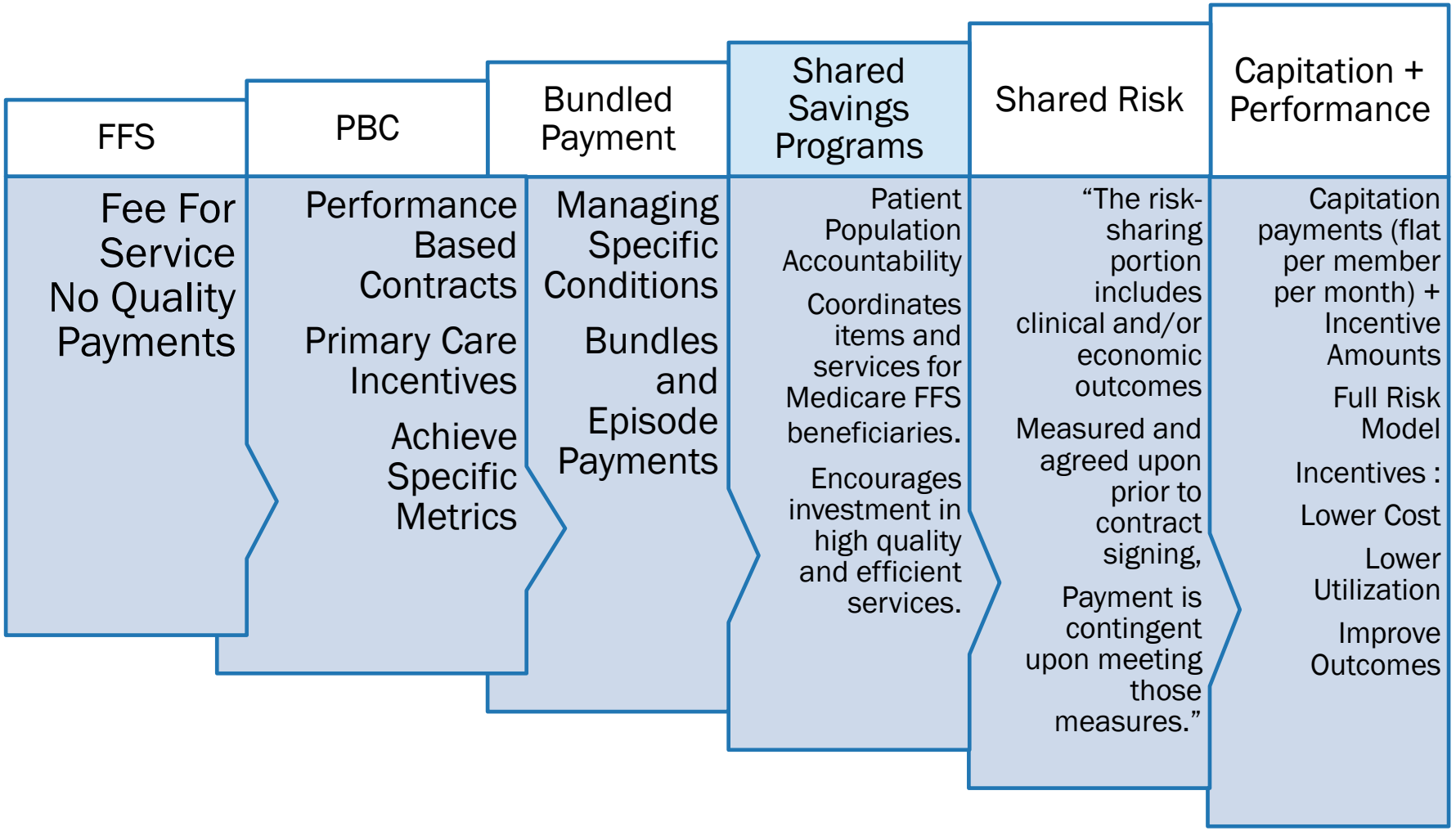
What is the Quality Payment Program?

The Medicare Access and CHIP Reauthorization Act of 2015 (MACRA) ended the Sustainable Growth Rate (SGR) formula, which would have resulted in a significant cut to Medicare payment rates for clinicians. MACRA advances a forward-looking, coordinated framework for clinicians to successfully participate in the Quality Payment Program (QPP), which is composed of 2 tracks:

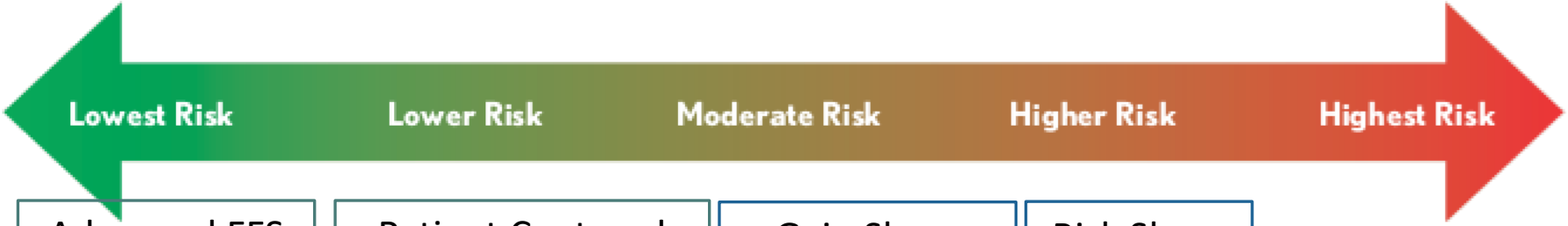
TRANSITION FROM MIPS TO [VALUE PAYMENTS]



THE SPECTRUM OF QUALITY PAYMENT PROGRAMS



SPECTRUM OF RISK IN VALUE-BASED ARRANGEMENTS



Advanced FFS (DRGS, APCS)	Patient Centered Medical Home (PCMH)	Gain Share	Risk Share	Global Payment Capitation
Shared Savings (Upside Only)	Pay For Performance	Episode & Other Specialist Programs (Bundled Payments, etc.)		

- Incentives/penalties applied to provider payments to promote improved outcomes
- Provider payments for investments in care delivery, care coordination and health IT (infrastructure)
- Financial incentives for quality reporting
- Reward only payments for high-quality performance

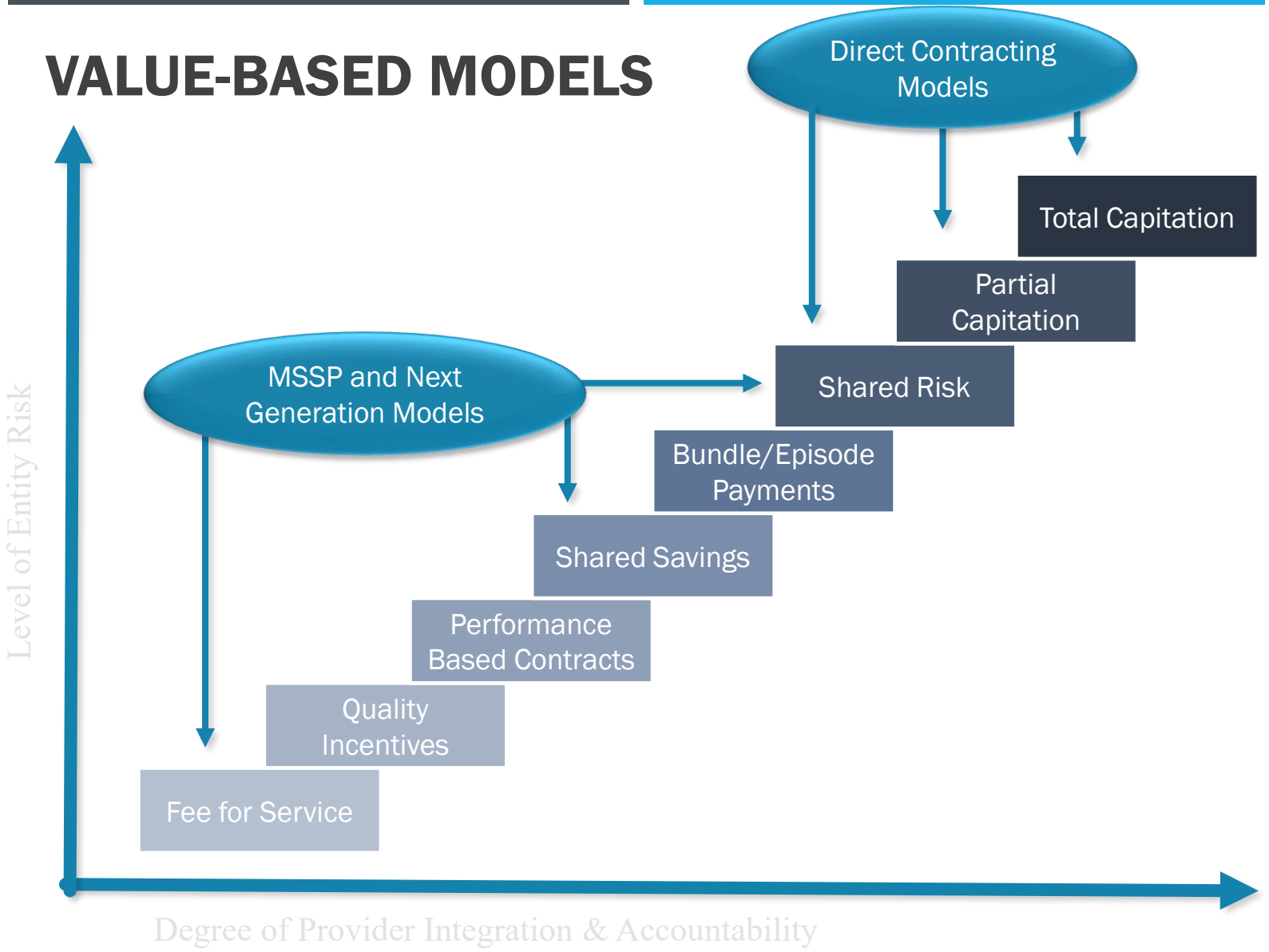
- Savings from care improvement shared between payer and provider
- Emerging care models with rewards or incentives
- Episode-based payment for clinical conditions

- Provider paid a single payment for a defined group of individuals
- Population-based payment for specific conditions
- Capitated payment based on care for a covered population
- Integrated payment and delivery systems (i.e., provider-based insurance plans)

5 STRATEGIC OBJECTIVES FOR ADVANCING SYSTEM TRANSFORMATION

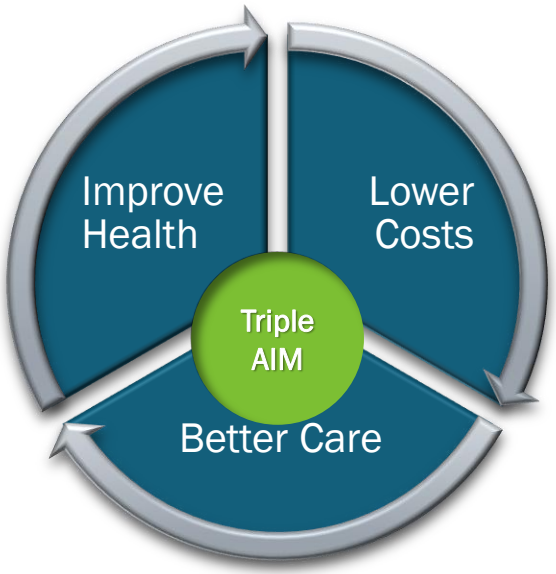
CMS Innovation Center is launching a bold new strategy with the goal achieving equitable outcomes through high-quality, affordable, person-centered care. The strategic objectives above will guide the Innovation Center's second decade.

VALUE-BASED MODELS



Value-Based Program =
Care delivery reform
+
Quality component
+
Payment reform

Value-based care doesn't describe a single model, but a spectrum of models



MEDICARE SHARED SAVINGS

ACCOUNTABLE CARE ORGANIZATIONS

BASIC TRACK (5 YEARS) – MIN. 5,000 BENEFICIARIES

An ACO in the Basic Track will automatically progress to the next level of risk annually

Basic Track (A & B)

163 ACOs

- Upside Only: Similar to Track 1 from previous rules
- Savings Rate: 40%
- Shared Loss Rate: 0%
- No Advanced APM Qualification
- Attribution: Prospective or Retrospective

Basic Track (C & D)

31 ACOs

- Two-Sided Risk
- Savings Rate: 50%
- Shared Loss Rate: 30%; capped at 2-4% of ACO revenue
- No Advanced APM Qualification
- Attribution: Prospective or Retrospective

Basic Track (E)

69 ACOs

- Two-Sided Risk
- Savings Rate: 50%
- Shared Loss Rate: 30%; capped at 8% of ACO revenue,
- Advanced APM Qualification
- Attribution: Prospective or Retrospective

ENHANCED TRACK (5 YEARS) – MIN. 5,000 BENEFICIARIES

Enhanced Track – *76 ACOs*

- Two-Sided Risk
- Savings Rate: 75%
- Shared Loss Rate: 40-70%; capped at 15% of benchmark
- Advanced APM Qualification
- Attribution: Prospective or Retrospective

Comparison to Other Programs

	Medicare Shared Savings Program	Direct Contracting (REACH) [Professional/Global]	Direct Contracting (Geographic)	Medicare Advantage
Risk Covered	Total cost of care	Primary care services / Total cost of care	Total cost of care / Partial Cost of care	Total cost of care
Programmatic Incentives	• Reduce total costs • High quality care	• Increase primary care services • Bring care in network • High quality care	• Bring care in network • High quality care • Manage many beneficiaries in a region	• Reduce total costs • Bring care in network • High quality care
Payment Structures	*FFS + reconciliation for shared savings/losses*	PBP + performance reconciliation	PBP + performance reconciliation	Capitation
Comparison Cohort	• Own historic experience • Regional/national assignable population	• Own historic experience • Regional USPCC	• Regional USPCC	• County level USPCC
Flexibility in Waivers/Beneficiary Incentives	• Few waivers • Optional benefit for E&M services	• Beneficiary incentives • Many waivers	• Beneficiary incentives • Many waivers	• Benefit flexibility options • Uniformity flexible benefits
Additional Infrastructure Requirements	N/A	• Capitation distribution to participating providers	• Capitation distribution • Payment of non-network FFS claims	• Provider reimbursement • Risk sharing arrangement
Alignment/Assignment	Prospective/Retrospective	Prospective	Regional	Voluntary alignment
Risk Adjustment	3% upside, unlimited downside; across entire 5-year agreement period	Medicare Advantage Risk Adjustment with Normalization and Coding Intensity Factor Adjustments	Zero-Sum Risk Coding	Medicare Advantage risk adjustment process

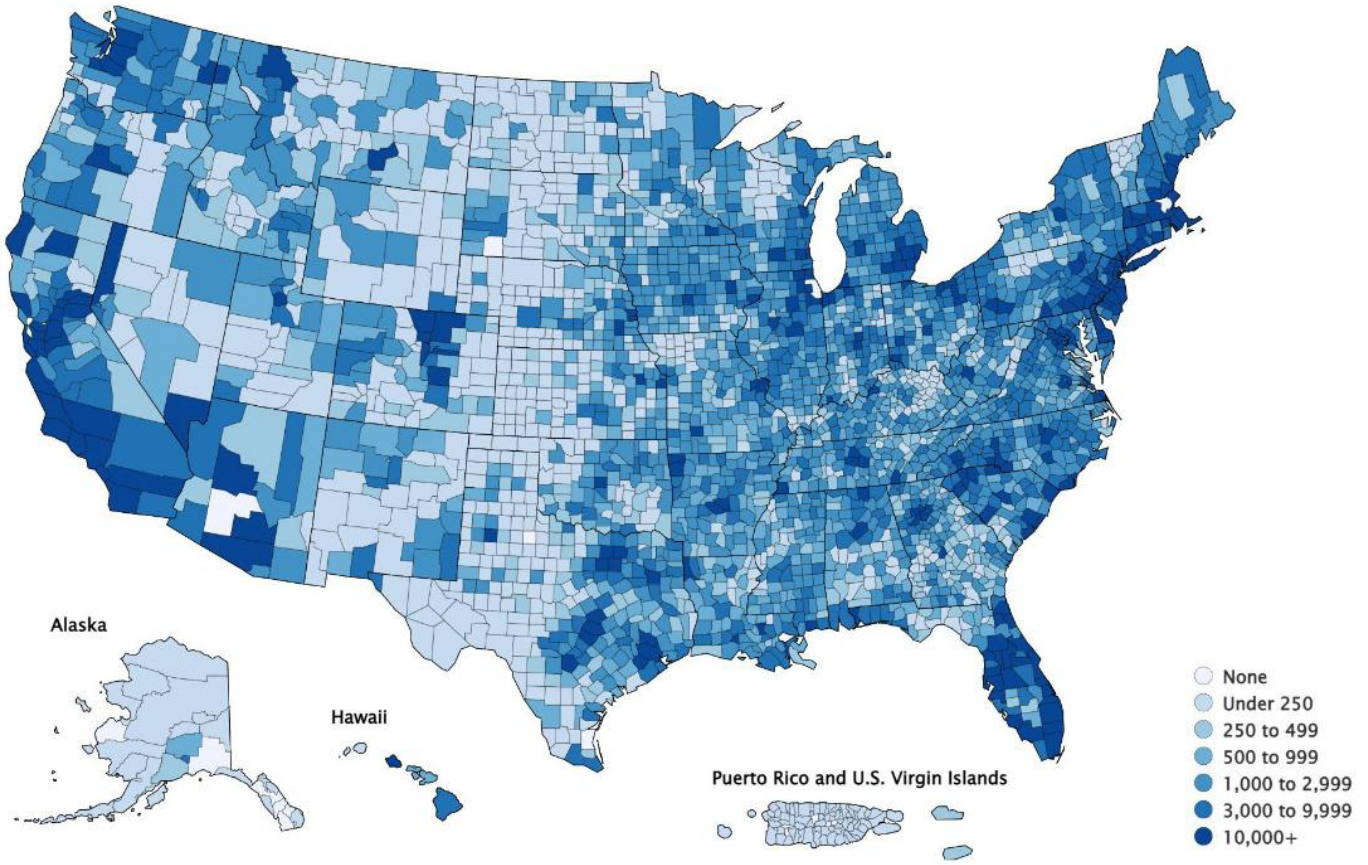
MEDICARE SHARED SAVINGS PROGRAM

Assigned Beneficiary Population by County

Shared Savings Program Fast Facts – As of January 1, 2023

CMS | MEDICARE SHARED SAVINGS PROGRAM

Medicare Shared Savings Program ACO Assigned Beneficiary Population by County



TYPICAL ACO MEASURES

- Care Management Services
- Annual Wellness Visits
- Transitional Care Management
- Preventive Screenings
- ER Visits and Re-Admissions
- ICD-10 Coding (HCC)

TYPICAL* ACO ANALYTICS

- Patient Attribution
- Annual Wellness Visit History
- Documented Disease Burden
- Patient Outreach
- Hospitalizations/ER Visits

TYPICAL* REVENUE SPLIT

GENERIC MEDICARE-SHARED SAVINGS PLAN TRACK A

50 - 60% of Revenue => Providers

40-50% of Revenue => ACO

Does not [usually] include downside risk.

MEDICARE, MEDICARE ADVANTAGE, MEDICAID MCOS, COMMERCIAL PAYERS

Medicare Advantage and Commercial health plans contracts with CMS are based upon pay for performance.

Provider contracts align with payer incentives.

STARS 5 components include:

- ✓ quality/HEDIS measures data,
- ✓ member CAHPS surveys,
- ✓ member HOS surveys,
- ✓ Pharmacy/Part D measures data,
- ✓ health plan operations data.

Commercial Payers are increasingly paying for performance!

CAHPS

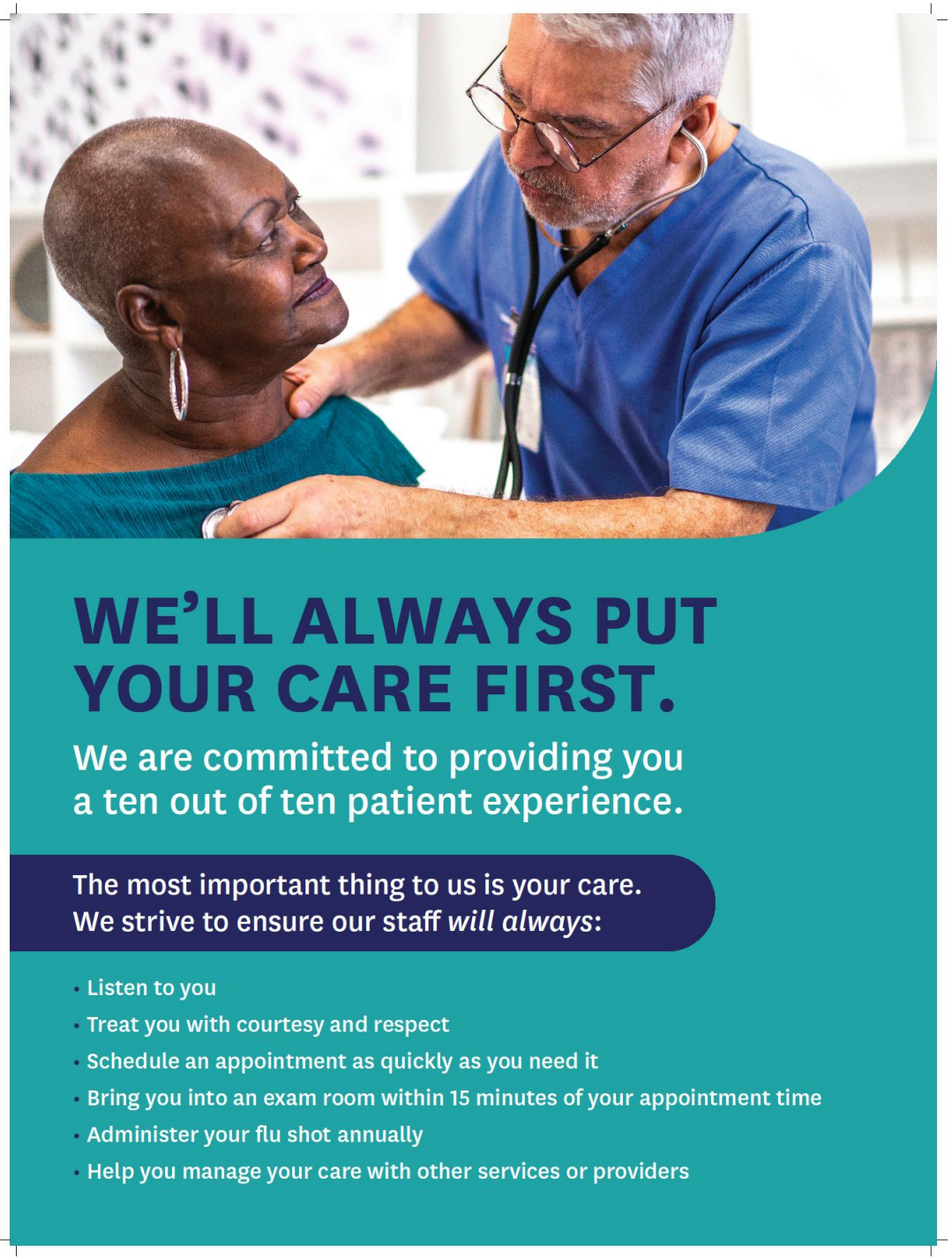
Consumer Assessment of Healthcare Providers and Systems

Surveys are developed by Agency for Healthcare Research & Quality (AHRQ)

It is a standardized tool used among health plans & prescription drug plans regarding member experience

CAHPS is used for:

- ✓ Accreditation/Star Rating
- ✓ Health Plan Ratings (HPR)
- ✓ Report Card



CAHPS FOCUS

Domain	CAHPS Questions	
Getting Needed Care and Getting Care Quickly	In the last 6 months, how often was it easy to get the care, tests or treatment you needed?	**Best Practices** – Ensuring patients have an appointment as needed based on assessment of their need to obtain care – Following up with patients to ensure they are able to schedule an appointment with specialist – Ensuring they have appointments available for patients that need urgent care – Offering patients a possible appt due to a cancellation – Offering patients a telehealth appt if office has capability – Ensuring access and availability standards are met – Monitoring time spent in waiting and exam rooms – Notifying patients if there is a delay in seeing their provider
	In the last 6 months, how often did you get an appointment to see a specialist as soon as you needed?	
	In the last 6 months, when you needed care right away, how often did you get care as soon as needed?	
	In the last 6 months, how often did you get an appointment for a check-up or routine care as soon as you needed?	
	Wait time includes time spent in the waiting room and exam room. In the last 6 months, how often did you see the person you came to see within 15 minutes of your appointment time?	

Confidential and Proprietary Information

CAHPS FOCUS

Domain	CAHPS Questions	
How well Doctors Communicate	In the last 6 months, how often did your personal doctor explain things in a way that was easy to understand?	**Best Practices:** - Ensure patients understand the information provided to them and their next steps – Follow-up with patients for any questions or concerns they may have – Following up with patients to ensure they have the appointments, results needed – Offering patients a telehealth appt if office has capability – Ensuring appointments are scheduled to provide enough time for patients questions – Monitoring time spent in waiting and exam rooms – Notifying patients if there is a delay in seeing their provider
	In the last 6 months, how often did your personal doctor listen carefully to you?	
	In the last 6 months, how often did your personal doctor show respect for what you had to say?	
	In the last 6 months, how often did your personal doctor spend enough time with you?	

Confidential and Proprietary Information

Key Medicare Quality Measures

2024 VS. 2025 VS. 2026 QUALITY MEASURES FOR ACOS

RURAL ADVANTAGE

These are quality measures that are to be submitted from the participants in addition to CAHPs measures and claims measures. Due to the submission type changing (moving to electronic only) the measure set is also changing and will be morphing between 2025 to 2028.

2024 Quality Measures	2025 Quality Measures	2026 Quality Measures
• Falls Risk Screening • Diabetes Control A1C • Blood Pressure Control • Depression Remission • Depression Screen and Follow Up Plan • Breast Cancer Screening • Colorectal Cancer Screening • Influenza Immunization • Tobacco Use and Cessation • Statin Therapy/Prevention CVD	• Diabetes Control A1C • Blood Pressure Control • Depression Screen and Follow Up Plan • Breast Cancer Screening	• Diabetes Control A1C • Blood Pressure Control • Depression Screen and Follow Up Plan • Breast Cancer Screening • Colorectal Cancer Screening

QUALITY MEASURE SETS

Beginning with the CY 2025 performance period there are 2 quality measure sets available under the Alternative Payment Model (APM) Performance Pathway (APP): the existing APP quality measure set and the new APP Plus quality measure set.

- the existing APP quality measure set
- **the new APP Plus quality measure set**

2025 QUALITY MEASURE SET – 6 MEASURES

Quality ID: 001	Diabetes: Glycemic Status Assessment Greater Than 9% (formerly Diabetes: Hemoglobin A1c (HbA1c) Poor Control)	Medicare Part B Claims**, Medicare CQM***
Quality ID: 112	Breast Cancer Screening	Medicare Part B Claims**, Medicare CQM***
Quality ID: 134	Preventive Care and Screening: Screening for Depression and Follow-up Plan	Medicare Part B Claims**, Medicare CQM***
Quality ID: 236	Controlling High Blood Pressure	Medicare Part B Claims**, Medicare CQM***
Quality ID: 321	CAHPS for MIPS Survey	CAHPS for MIPS Survey
Quality ID: 479	Hospital-Wide, 30-day, All-Cause Unplanned Readmission	Administrative Claims

MEDICARE ADVANTAGE AND VALUE BASED CARE: CLOSING CARE GAPS

TAKE ADVANTAGE OF VALUE-BASED DOLLARS NOW!!

MEDICARE ADVANTAGE GAPS

All Medicare Advantage plans are scored by CMS in almost exactly the same manner as ACO participants are in “value-based” care arrangements.

Wellcare Medicare 2024 P4Q

Wellcare Medicare Provider Portal
866-592-5832 M-F 7a-5p CST
https://provider.wellcare.com

Wellcare Medicare P4Q New in 2023

- Increased base payments by $20 to $40 a measure
- Removed 3-, 4- & 5-STAR target performance
- Added a 50% bonus increase by achieving an aggregate STAR rating of 4.0 or higher across HEDIS and pharmacy measures
- Provider obtains a base rate for every member who completes a measure
- First three payments will reflect base level. Final true-up payment the following year (2nd or 3rd quarter) will reflect any earned bonus amounts on HEDIS & pharmacy measures
- All claims, encounters, and data submissions must be received by 1/31/24 to be eligible for incentives

See attached booklet for more information

2023 Partnership for Quality

wellcare

Wellcare understands that the provider-member relationship is a key component in ensuring superior healthcare and the satisfaction of our members. Because Wellcare recognizes these important partnerships, we are pleased to offer the 2023 Partnership for Quality (P4Q) Bonus Program, which rewards PCPs for improving quality and closing gaps in care.

The P4Q Program includes a bonus enhancement to better align payment with quality. **Providers can now potentially earn a 50% bonus increase by achieving an aggregate STAR Rating of 4.0 or higher across HEDIS® and Pharmacy measures.**

Program Measures	Amount Per
BCS – Breast Cancer Screening	$50
CBP – Controlling High Blood Pressure	$50
Diabetes – Dilated Eye Exam	$40
Diabetes HbA1c <= 9	$50
COA – Care for Older Adults – Pain Assessment*	$25
COA – Care for Older Adults – Review*	$25
COL – Colorectal Cancer Screen	$50
FMC – F/U ED Multiple High Risk Chronic Conditions	$40
Medication Adherence – Blood Pressure Medications	$50
Medication Adherence – Diabetes Medications	$50
Medication Adherence – Statins	$50
OMW – Osteoporosis Management in Women Who Had Fracture	$50
SPC – Statin Therapy for Patients with CVD	$50
SUPD – Statin Use in Persons With Diabetes	$50
TRC – Medication Reconciliation Post Discharge	$25
TRC – Patient Engagement after Inpatient Discharge	$25

Special Needs Plan (SNP) members only

APPOINTMENT AGENDAS FOR WELLCARE, MERIDIAN & AMBETTER

The CoC program is designed to support outreach **Appointment Agendas for Wellcare, Meridian & Ambetter** to members for annual visits and condition management, which helps to identify members eligible for case management.

- ✓ Providers earn bonus payments for proactively coordinating preventative medicine and for thoroughly addressing patients' current conditions to improve health and clinical quality of care.
- ✓ ***This is a claims-based program.*** Members need to be assessed during the year by their PCP, along with a claim submitted to support the provider's assessment.
- ✓ Bonuses are paid per NPI for each completed agenda (disease condition/continuity of care portion only) with verified/documented diagnoses.
- ✓ Refer to each line of business program manual for specific terms and conditions

2023 Continuity of Care Program

PROGRAM STARTS FEBRUARY 2023

wellcare

meridian

2023 Continuity of Care Program

PROGRAM STARTS FEBRUARY 2023

Threshold % of AAs completed per NPI	Medicare bonus p/agenda-includes $100 additional bonus	Medicaid bonus p/agenda
< 50%	$200	$100
≥ 50% to < 80%	$300	$200
≥ 80%	$400	$300

COMMERCIAL AND MEDICAID MCOS

Check with ALL of your payers to ensure enrollment in the quality program they offer.

There is often NO enrollment, just registration on Quality Website.

Provider representatives are usually eager to help.

MOST RHCS ARE NOT REPORTING QUALITY VISITS CORRECTLY.

ONE IN TEN REVIEWED BY THE AUTHOR HAVE BEEN CORRECT.

COMMON MISCONCEPTIONS

An RHC claim MUST have an Evaluation and Management code: FALSE.

Only one encounter is paid, so we CANNOT provide a sick visit and AWV/SAWV at the same time: FALSE.

In most circumstances, only one encounter is PAYABLE. All are REPORTABLE!

BILLING EXAMPLE: OFFICE VISIT W/ ANNUAL WELLNESS VISIT

FL42 Rev CD	FL43 Desc	FL44 HCPCS/CPT	FL45 DOS	FL46 Units	FL47 Total Charge
0521	Est Patient Level 4	99214CG	04/02/2022	1	$ 150.00
0521	Annual Wellness Visit	G0438	04/02/2022	1	$ 120.00
0001	Total Charge				$ 270.00

"Modifier CG should be reported only with the medical service HCPCS code that represents the primary reason for the medically necessary face-to-face visit when medical and preventive services are furnished on the same day."

RHC Reporting FAQ

RHCS AND STAND-ALONE ENCOUNTERS

"Stand Alone" encounter is the only service rendered on a particular date of service, then it will be paid at the AIR.

Stand-Alone Encounters on the same RHC claim as another is not separately reimbursed.

IT SHOULD/MUST BE REPORTED on the RHC claim!!

PATIENT TRANSPORTATION SECURITY

CMS does NOT allow a policy of requiring patients to return on a different day/time in order to provide annual wellness visits, or vice-versa.

CMS wants us to treat the patient while they are there.

There IS flexibility for Medical Judgement.

OFFICE VISIT AND ANNUAL WELLNESS VISIT/ACP

An established patient is seen and a qualifying visit of 99214 for $150 is generated. An Annual Wellness Visit was also performed for $120.00. A venipuncture was performed for $20.00.

FL42 Rev CD	FL43 Desc	FL44 HCPCS/CPT	FL45 DOS	FL46 Units	FL47 Total Charge
0521	OV Est 4	99214 CG	01/09/2023	1	$ 170.00
0521	Annual Wellness Visit	G0438	01/09/2023	1	$ 120.00
0521	Advanced Care Planning	99496	01/09/2023	1	$ 100.00
0001	Total Charge				$ 390.00

- ✓ The charge for the AWV and ACP are NOT be bundled in the 99214 line.
- ✓ The AWV and ACP do not result in direct reimbursement.
- ✓ If properly reported, this visit represents 6.02 wRVUs!!

BILLING EXAMPLE: WELL-WOMAN EXAM

Medicare does not pay a well-woman exams (99381-99387). An annual or subsequent wellness visit (G0438/G0439) is reported for the examination, plus the breast/pelvic exam (G0101), and the pap smear (Q0091). This visit would be paid as ONE encounter.

FL42 Rev CD	FL43 Desc	FL44 HCPCS/CPT	FL45 DOS	FL46 Units	FL47 Total Charge
0521	Subsq AWV	G0439 CG	04/02/2023	1	$ 175.00
0521	Breast/Pelvic	G0101	04/02/2023	1	$ 75.00
0521	Pap Smear	Q0091	04/02/2023	1	$ 50.00
0001	Total Charge				$ 300.00

All Preventive Services are listed to capture quality measure and to report utilization to Medicare for COB. The patient is not responsible for any co-insurance or deductible for these Medicare Preventive Services.

BILLING EXAMPLE: OFFICE VISIT WITH DIABETIC COUNSELING*

FL42 Rev CD	FL43 Desc	FL44 HCPCS/CPT	FL45 DOS	FL46 Units	FL47 Total Charge
0521	Est Patient Level 4	99214CG	04/02/2022	1	$ 150.00
0521	DSMT	G0108	04/02/2022	1	$ 80.00
0521	Medical Nutrition Therapy	97803	04/02/2022	1	$ 80.00
0001	Total Charge				$ 310.00

The MD/DO/NP/PA has seen the patient and a Diabetic Nurse Educator comes in to provide additional counseling and nutrition training.

*Coinsurance will be applied to this encounter!

BILLING EXAMPLE: TOBACCO CESSATION!!!

FL42 Rev CD	FL43 Desc	FL44 HCPCS/CPT	FL45 DOS	FL46 Units	FL47 Total Charge
0521	Est Patient Level 4	99214CG	04/02/2022	1	$ 150.00
0521	Tobacco Cessation > 3 Min	99406	04/02/2022	1	$ 15.00
0001	Total Charge				$ 165.00

- ✓ Tobacco Cessation will not increase co-insurance.
- ✓ Charges for Preventive Services are NEVER bundled with the CG Line Item.
- ✓ 99406 is for information only, but critically important to report!

BILLING EXAMPLE: TOBACCO CESSATION!!!

FL42 Rev CD	FL43 Desc	FL44 HCPCS/CPT	FL45 DOS	FL46 Units	FL47 Total Charge
0521	Tobacco Cessation > 3 Min	99406	04/02/2022	1	$ 15.00
0001	Total Charge				$ 15.00

ANY of the Stand-Alone Medicare Preventive Screenings are paid as RHC Encounters when no other services are rendered.
Co-Insurance is not applied.

BILLING EXAMPLE: IBT OBESITY

FL42 Rev CD	FL43 Desc	FL44 HCPCS/CPT	FL45 DOS	FL46 Units	FL47 Total Charge
0521	IBT Obesity	G0447	01/05/2023	1	$ 100.00
0001	Total Charge				$ 100.00

Frequency:

We pay up to 22 visits billed with codes G0447 and G0473, combined, in a 12-month period:

- First month: 1 face-to-face visit every week.
- Months 2–6: 1 face-to-face visit every other week.
- Months 7–12: 1 face-to-face visit every month if patient meets certain requirements.

BILLING EXAMPLE: OFFICE VISIT WITH PREVENTIVE SERVICES

FL42 Rev CD	FL43 Desc	FL44 HCPCS/CPT	FL45 DOS	FL46 Units	FL47 Total Charge
0521	Est Patient Level 4	99214 CG	04/02/2022	1	$ 150.00
0521	Advanced Care Planning	99497	04/02/2022	1	$ 75.00
0521	Alcohol Screening	G0422	04/02/2022	1	$ 50.00
0521	IBT for Obesity	G0447	04/02/2022	1	$ 50.00
0001	Total Charge				$ 325.00

Modifier CG identifies the line service for which co-insurance and deductible should be applied. The additional preventive services are for information only.

HCC CODES – RHCS ARE NOT PREPARED

THE “UNSPECIFIED” KISS OF DEATH FOR VALUE-BASED CARE

WHAT IS HCC CODING?

Hierarchical condition category (HCC) coding is a risk-adjustment model originally designed to estimate future health care costs for patients.

Hierarchical Condition Category Coding. https://www.aafp.org/family-physician/practice-and-career/getting-paid/coding/hierarchical-condition-category.html. 2025 American Academy of Family Physician**.**

HCC AND ICD-10

- HCC coding relies on ICD-10-CM coding to assign risk scores to patients.
- Each HCC is mapped to an ICD-10-CM code
- Along with demographic factors such as age and gender, insurance companies use HCC coding to assign patients a risk adjustment factor (RAF) score.

Hierarchical Condition Category Coding. https://www.aafp.org/family-physician/practice-and-career/getting-paid/coding/hierarchical-condition-category.html. 2025 American Academy of Family Physician.

WHAT IS HCC CODING?

Using algorithms, insurance companies can use a patient's

RAF score to predict costs.

For example, a patient with few serious health conditions could be expected to have average medical costs for a given time. However, a patient with multiple chronic conditions would be expected to have higher health care utilization and costs.

Hierarchical Condition Category Coding. https://www.aafp.org/family-physician/practice-and-career/getting-paid/coding/hierarchical-condition-category.html. 2025 American Academy of Family Physician.

RISK SCORE UNDERVALUING PATIENT COST

When risk scores do not accurately reflect patient complexity, it may appear patients had higher costs and/or lower quality outcomes than would be expected.

Hierarchical Condition Category Coding. https://www.aafp.org/family-physician/practice-and-career/getting-paid/coding/hierarchical-condition-category.html. 2025 American Academy of Family Physician.

RISK ADJUSTMENT CALCULATION METHOD

Jane is a 68-year-old female patient with type 2 diabetes with no complications, hypertension, and a body mass index (BMI) of 38.2*

ICD-10-CM	Description	RAF
	Demographics (age and gender)	0.323
E11.9	Diabetes type II without complications	0.105
I10	Hypertension	0.00
Z68.37	BMI of 37.5	0.00
		0.428

Hierarchical Condition Category Coding. https://www.aafp.org/family-physician/practice-and-career/getting-paid/coding/hierarchical-condition-category.html. 2025 American Academy of Family Physician.

EXAMPLE 2

- Type 2 diabetes mellitus with diabetic polyneuropathy
- Hypertension
- Morbid (severe) obesity due to excess calories and body mass index (BMI) 38.0-38.9
- Heart failure, unspecified (includes congestive heart failure not otherwise specified)
- Disease interaction (DM + CHF)

ICD-10-CM	Description	RAF
	Demographics (age and gender)	0.323
E11.9	Diabetes type II without complications	0.105
E66.01 & Z68.38	Morbid (severe) obesity due to excess calories and body mass index (BMI) 38.0-38.9	0.250
I50.9	Heart failure, unspecified (includes congestive heart failure not otherwise specified)	0.331
	Disease interaction (DM + CHF)	0.121
	Total Optimized Risk	1.327

Hierarchical Condition Category Coding. https://www.aafp.org/family-physician/practice-and-career/getting-paid/coding/hierarchical-condition-category.html. 2025 American Academy of Family Physician.

SOCIAL DETERMINANTS OF HEALTH Z CODES ARE INCLUDED IN THE FOLLOWING Z CODE CATEGORIES

Z55 – Problems related to education and literacy

Z56 – Problems related to employment and unemployment

Z57 – Occupational exposure to risk factors

Z58 – Problems related to physical environment

Z59 – Problems related to housing and economic circumstances

Z60 – Problems related to social environment

Z62 – Problems related to upbringing

Z63 – Other problems related to primary support group, including family circumstances

Z64 – Problems related to certain psychosocial circumstances

Z65 – Problems related to other psychosocial circumstances

Hierarchical Condition Category Coding. https://www.aafp.org/family-physician/practice-and-career/getting-paid/coding/hierarchical-condition-category.html. 2025 American Academy of Family Physician**.**

HCC TIPS

Code to the highest level of specificity and ensure the diagnoses are properly sequenced on the claim.

Type and underlying cause (e.g., diabetes type 1 or 2, due to underlying condition, postprocedural or due to genetic defects, etc.)

Hierarchical Condition Category Coding. https://www.aafp.org/family-physician/practice-and-career/getting-paid/coding/hierarchical-condition-category.html. 2025 American Academy of Family Physician.

HCC TIPS

Some things to consider when selecting the appropriate diagnosis code:

- ✓ Type and underlying cause (e.g., diabetes type 1 or 2, due to underlying condition, postprocedural or due to genetic defects, etc.)
- ✓ Control status
- ✓ Severity
- ✓ Site, location, or laterality
- ✓ Associated co-morbid conditions
- ✓ Substance use/exposure

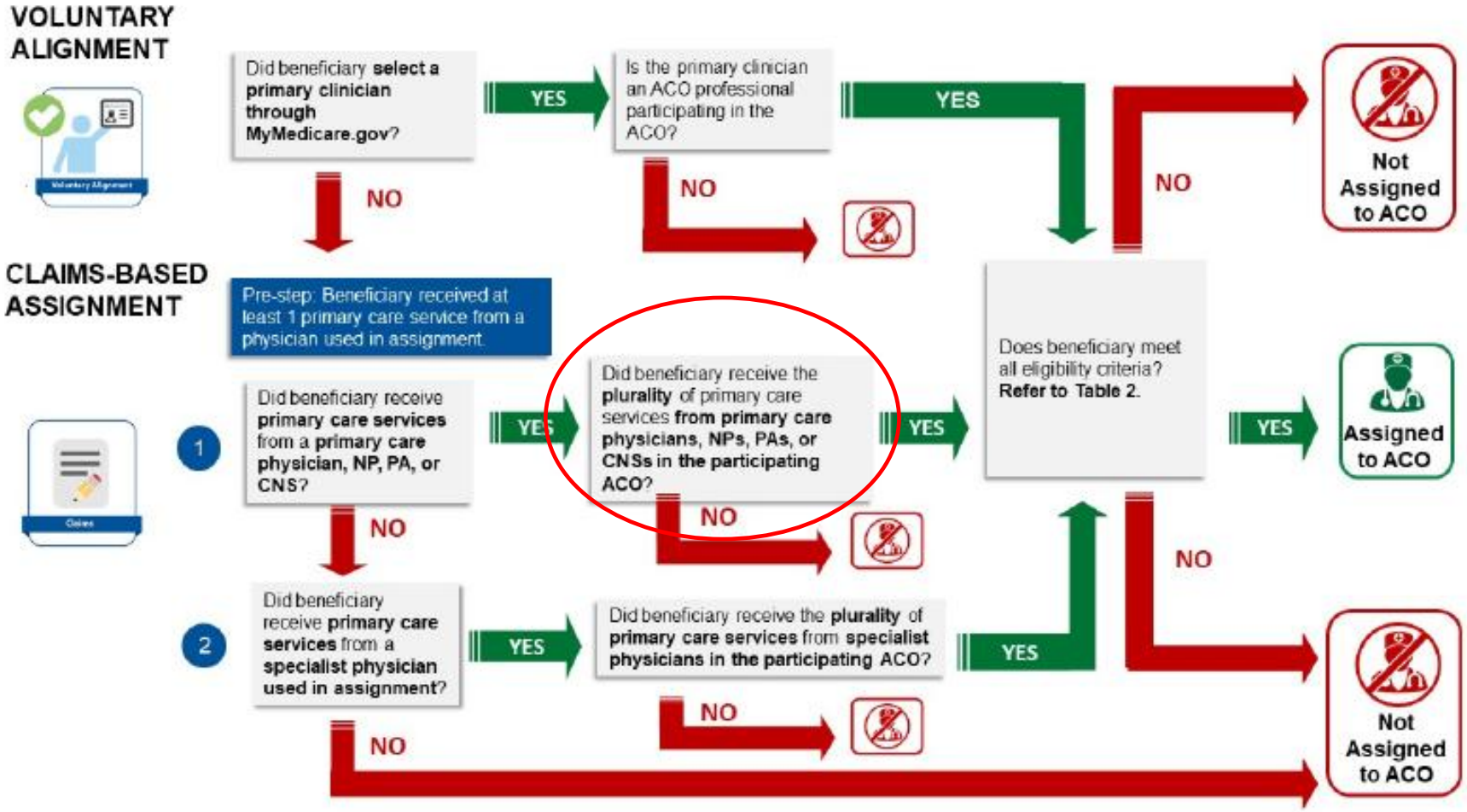
Hierarchical Condition Category Coding. https://www.aafp.org/family-physician/practice-and-career/getting-paid/coding/hierarchical-condition-category.html. 2025 American Academy of Family Physician.

PATIENT ATTRIBUTION AND PREVENTIVE SERVICES

"PLURALITY OF SERVICES"

WHO ARE YOUR MEDICARE PATIENTS…ACCORDING TO MEDICARE?

MEDICARE SHARED SAVINGS PROGRAM



MEDICARE PREVENTIVE SERVICES CHART

mln EDUCATIONAL TOOL
KNOWLEDGE • RESOURCES • TRAINING

Print

Telehealth Eligible Service

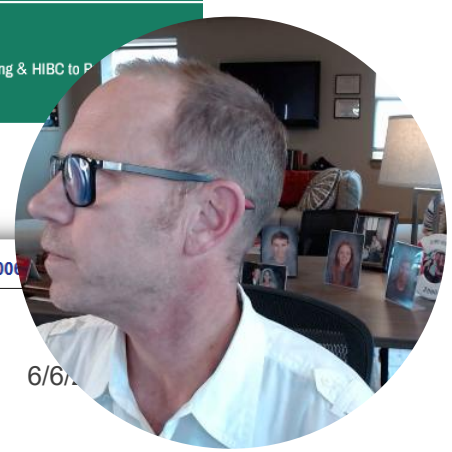
Medicare Preventive Services

Select a Service | FAQs | Resources

Alcohol Misuse Screening & Counseling (T)	Annual Wellness Visit (T)	Bone Mass Measurements	Cardiovascular Disease Screening Tests	Cervical Cancer Screening	Colorectal Cancer Screening	Counseling to Prevent Tobacco Use (T)
Depression Screening (T)	Diabetes Screening	Diabetes Self-Management Training (T)	Flu Shot & Administration	Glaucoma Screening	Hepatitis B Screening	Hepatitis B Shot & Administration
Hepatitis C Screening	HIV Screening	IBT for Cardiovascular Disease (T)	IBT for Obesity (T)	Initial Preventive Physical Exam	Lung Cancer Screening (T)	Mammography Screening
Medical Nutrition Therapy (T)	Medicare Diabetes Prevention Program	Pap Tests Screening	Pneumococcal Shot & Administration	Prolonged Preventive Services (T)	Prostate Cancer Screening	STI Screening & HIBC to P
Screening Pelvic Exams	Ultrasound AAA Screening					

Quick Start | Advance Health Equity

MLN00



IT IS TIME FOR PRIMARY CARE TO EVOLVE.

IT IS TIME TO CHANGE HOW WE THINK.

The priority is no longer whether two encounters are PAID. The priority is that all preventive services are performed and REPORTED – for ALL payers!!

Overall Revenue Increase: 10 – 17%.

Why does the doctor want me to come back?

“I was just there.”

WELLCARE QUALITY RESOURCES

For additional information on specific HEDIS® measures, see Quick Reference Guide (QRG):

IL Meridian Health Plan https://ilmeridian.com/providers/resources/quality-improvement.html

Wellcare wellcare.com/Illinois/Providers/Medicare/Quality

YouthCare ilyouthcare.com/content/dam/centene/meridian/il/pdf/YouthCare2022-HEDIS-QRG-R4_Final.pdf

Email ILHEDISOps@mhplan.com

RESOURCES

"What are Value Based Payment Programs". www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/Value-Based-Programs/Value-Based-Programs.html. Centers for Medicare and Medicaid Services. 07/16/2019. Accessed 5.23.2023.

Quality Measures Reporting. www.healthit.gov/topic/federal-incentive-programs/MACRA/MIPS/quality-measures-reporting. 2.12.2019. Accessed 5.23.2023

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