

KONTIKI STRATEGIC HEALTH ADVISORS

# RAF, MLR, and Value-Based Care: An Integrated Strategy for Attribution, Shared Savings, and Outmigration Reduction

Accelerating RAF Accuracy, MLR Performance, and Leakage Control in Medicare Advantage and ACO Risk Arrangements

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Includes: Operational Strategy • Visual Framework • No-Burnout Physician Model • Professional Terminology Reference

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## Executive Summary

The combination of high-cost patient utilization, incomplete HCC documentation, and referral outmigration remains the most significant and most correctable barrier to shared savings performance in Medicare Advantage and ACO risk arrangements. These three failures compound each other: underdocumented patients generate high costs without corresponding risk-adjusted revenue, while fragmented care outside the network drives those costs higher and removes the clinical touchpoints needed to correct the documentation.

This white paper presents an integrated strategy for simultaneously addressing RAF accuracy, MLR variance, attribution retention, and outmigration reduction. It includes the visual RAF–MLR quadrant framework for provider-level performance targeting, the operational components of an embedded care team model that captures RAF without increasing physician burden, and the professional terminology reference guide for managed care, value-based care, and revenue cycle management.

### The Strategic Premise

RAF reflects the true clinical complexity of a patient and drives payment accuracy. MLR reflects how much of that payment is actually spent on patient care. The highest-value opportunity in value-based care is always the same: patients with high MLR and low RAF. These patients have high utilization, incomplete chronic condition capture, documentation gaps, fragmented care, and incorrect or unstable attribution. Fixing these patients simultaneously reduces costs and increases revenue.

<p><b>High MLR + Low RAF</b></p> <p><b>Highest-priority patient target</b></p> <p>High cost, low reimbursement — worst outcome in VBC</p>	<p><b>\$10–12K</b></p> <p><b>Value per RAF point</b></p> <p>Annual revenue impact per 1.0 RAF point per attributed patient</p>	<p><b>20–25%</b></p> <p><b>Typical outmigration rate</b></p> <p>Fragmented systems without closed-loop referral management</p>	<p><b>&gt;85%</b></p> <p><b>In-network referral target</b></p> <p>Best-in-class CIN and MA network performance standard</p>
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## Section 1: Strategic Rationale — RAF and MLR as the Financial Engine of VBC

In a value-based care contract, revenue is not generated by the volume of services delivered. It is generated by the accuracy with which clinical complexity is documented and the efficiency with which that complex population is managed. RAF and MLR are the two financial levers that determine whether a practice earns margin or absorbs loss in a risk-based arrangement.

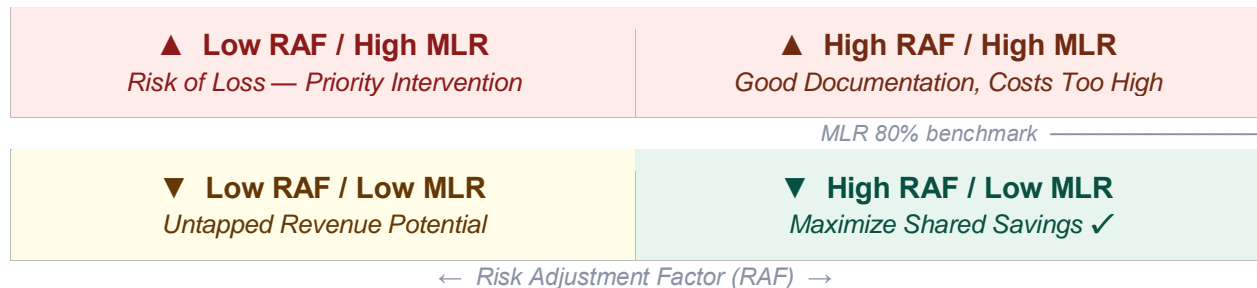
### 1.1 The Car Insurance Analogy for RAF and MLR

#### Understanding RAF and MLR Through a Familiar Model

Think of a patient as a car covered by an insurance plan. RAF is the car's risk score based on its condition — age, mileage, known mechanical issues. A car with more problems receives a higher repair budget from the insurance company. MLR is the percentage of that budget actually spent on fixing the car. If the insurance company collects \$100 and spends \$85 on repairs, the MLR is 85%. In healthcare: when RAF accurately reflects a patient's chronic disease burden, the organization receives adequate reimbursement to manage that patient's care. When MLR is controlled through coordinated care, the organization retains margin. Low RAF + High MLR = high repair costs with an inadequate budget. That is the worst financial outcome in value-based care, and it is the most common.

### 1.2 The Four RAF–MLR Performance Quadrants

The following framework maps provider panel performance across four quadrants defined by RAF score (clinical documentation completeness) and MLR (cost efficiency). Every practice panel falls into one of these quadrants, and each quadrant calls for a different operational response.



Quadrant	Clinical Meaning	Financial Outcome	Priority Action
<b>Low RAF / High MLR</b>	High utilization; chronic conditions underdocumented; care fragmented	Worst outcome: high cost + low reimbursement	<b>Immediate: schedule, document, coordinate</b>
<b>High RAF / High MLR</b>	Documentation accurate; costs elevated above benchmark	Good coding; utilization management needed	Strengthen care coordination; reduce OON utilization

<b>Low RAF / Low MLR</b>	Simple or underdocumented panel; costs low	Revenue below complexity level; VBC value limited	Improve documentation specificity; expand AWV program
<b>High RAF / Low MLR</b>	Complex patients well-documented; care coordinated	Optimal: reimbursement matches acuity; margin retained	Sustain; replicate workflows across other panels

### 1.3 The Practice Data in Context

When provider-level RAF and MLR data is plotted on the quadrant framework, patterns emerge that are invisible in standard financial reports:

- A practice with RAF of 0.92 and MLR of 85% is in the Low RAF / High MLR quadrant — the priority intervention zone. High cost without corresponding documentation.
- A practice with RAF of 1.22 and MLR of 82% sits in High RAF / High MLR — documentation is working; utilization management and outmigration reduction are the next levers.
- A practice with RAF of 1.20 and MLR of 78% is approaching the optimal quadrant — model for replication across the network.

#### The Operational Implication

These are not static positions. Every practice in the Low RAF / High MLR quadrant can move toward High RAF / Low MLR within two to four quarters through structured pre-visit preparation, AWV pairing with E/M and MEAT documentation, embedded care team support, and closed-loop referral management. The movement is measurable and financially quantifiable.

## Section 2: The No-Burnout Model — RAF Capture Without Increasing Physician Work

Physicians consistently report that they do not oppose RAF documentation or quality measures when workflows align with normal clinic operations and support staff prepare the chart effectively. The resistance to RAF programs in most organizations is not clinical — it is operational. When documentation improvement requires additional physician clicks, extra visit time, or after-hours charting, it creates burnout. When it is embedded into the existing workflow through pre-visit preparation, it disappears as a burden.

### 2.1 How This Strategy Protects Physician Time

- High-MLR / low-RAF patients are scheduled into existing templates, not into separate RAF visits
- Patients not seen in 12 months, high ED utilizers, outmigrators, and those without completed AWVs are prioritized through navigator outreach — not by the physician
- Charts are fully prepared before the physician enters the room: HCC opportunities identified, chronic conditions flagged, care gaps noted, medication list reconciled
- Medical assistants, LPNs, nurses, pharmacists, and coders complete screenings, care gap documentation, and medication reconciliation before and after the visit
- Embedded care team members embedded directly into practices with the highest MLR variance perform the AWV, schedule patient appointments, compile the problem list, and provide patients with orders for QIP measures such as diabetic eye exams

### 2.2 The Three-Phase Visit Structure

Phase	Responsible Role	Activities
<b>Pre-physician</b>	MA / LPN / Nurse	Perform all screenings (PHQ-9, fall risk, SDOH); close or document care gaps; identify unresolved chronic conditions; flag suspect HCCs; prepare problem list for physician confirmation; complete HRA for AWV
<b>Physician door time</b>	PCP / Physician	Clinical decision-making only; confirm active chronic conditions; update problem list; address abnormal screenings; complete assessment and plan with MEAT documentation
<b>Post-visit</b>	Care Coordinator / Coder	Final quality checks; follow-up scheduling to reduce outmigration; attribution verification; coding validation and RAF submission; 837-S supplemental file preparation

#### The Net Result

More accurate documentation. Higher RAF capture. Improved care coordination. No change to provider templates. No increase in visit length. No additional physician administrative burden. PCPs should have less work in a value-based care environment, not more — the operational infrastructure exists to support them.



## Section 3: Outmigration — The Hidden Financial Drain in Value-Based Care

Outmigration is the process by which attributed patients receive care outside the primary network — through out-of-network specialists, independent imaging centers, external hospitals, or unaffiliated urgent care facilities. In fee-for-service medicine, outmigration is primarily a revenue leakage problem. In value-based care, it is simultaneously a revenue problem, a documentation problem, a quality problem, and a cost problem.

### 3.1 Why Outmigration Is Worse in VBC Than in Fee-for-Service

Consequence of Outmigration	Fee-for-Service Impact	Value-Based Care Impact
Revenue loss	Lost procedural or diagnostic revenue	Lost revenue AND attribution risk AND shared savings reduction
RAF documentation gap	Not applicable	Out-of-network encounter = no HCC capture = RAF erosion
Care coordination failure	Suboptimal but common	Increases total cost of care; deteriorates MLR
Attribution drift	No financial impact	Patient may re-attribute to competing PCP; entire panel value lost
Duplicate testing	Billable if within network	Drives MLR up; no quality credit; patient dissatisfaction
Quality measure failure	Not financially penalized	HEDIS gap opens; Star Rating declines; quality bonus at risk

### 3.2 Root Causes of Outmigration

- Access delays: new patient wait times exceeding 14 days create 18% average out-migration rate
- No closed-loop referral management: patients given a specialist name and phone number rather than a scheduled appointment
- Emergency department and urgent care utilization outside the network without TCM follow-up to recapture the patient
- Patients with incorrect attribution or no active PCP relationship who self-navigate to external providers
- Imaging and diagnostics ordered without in-network scheduling: patients schedule at the nearest available facility rather than an in-network provider
- Specialty care unavailable within the network at acceptable wait times: particularly cardiology, orthopedics, and neurology

### 3.3 Outmigration Reduction Operating Standards

Intervention	Operational Standard	KPI
Closed-loop referral management	No referral order leaves without a scheduled appointment confirmed before patient exits the building	Referral → scheduled rate ≥ 90%
Same-day referral scheduling	Central navigation team contacts patient within 2 hours of referral placement	Same-day contact rate ≥ 80%
ED and inpatient TCM capture	All attributed patients discharged from ED or hospital contacted within 2 business days; visit within 7–14 days	TCM capture rate ≥ 60% of eligible
Access standards	Third next available appointment < 5 days PCP; < 7 days specialist	Access target met consistently
Imaging and diagnostic in-network	In-network imaging scheduled at time of order; patient not self-navigating	In-network imaging rate ≥ 85%
Attribution correction	Quarterly audit of attributed panel; incorrect or lapsed attribution corrected with payer and EMR	Attribution accuracy ≥ 95%

### 3.4 The Compounding Effect: Outmigration Drives MLR Up While RAF Goes Down

#### Why Outmigration Creates a Double Loss

When an attributed patient receives an MRI at an out-of-network imaging center, the organization loses the diagnostic revenue. When that patient then sees an out-of-network orthopedic surgeon, the organization loses the surgical revenue and the care coordination that would have managed the post-operative course. When the surgeon documents new diagnoses without those diagnoses entering the network's EMR, the HCCs are never submitted and the RAF score falls. The same episode of care has now produced: lost revenue, higher costs (no utilization management), lower RAF, and attribution risk. This is why outmigration reduction is not an access initiative. It is a financial strategy.

## Section 4: Managed Care and Value-Based Care — How the Financial Model Works

Understanding managed care and value-based care payment structures is foundational to making operational decisions that align clinical activity with financial performance. The following section explains the key models, their financial mechanics, and the operational levers that determine whether an organization earns margin or absorbs loss under each arrangement.

### 4.1 The Fee-for-Service to Value-Based Care Continuum

Model	Payment Mechanism	Revenue Driver	Risk to Organization
Fee-for-service	Paid per service rendered	Volume of encounters and procedures	Payer denials; contract rates; charge capture
Pay-for-performance	FFS plus quality bonuses	Volume plus quality metric achievement	Denial risk plus quality measure failure
Shared savings (upside only)	FFS plus share of savings below benchmark	Volume plus cost efficiency plus documentation	Inability to bend cost curve; RAF erosion
Shared savings and risk	FFS plus/minus shared savings and losses	Volume, cost, documentation, attribution	All of the above plus financial downside
Global capitation	Fixed PMPM for all services	Attribution retention; cost management	Full financial risk for all attributed patients

### 4.2 Medicare Advantage: How Risk-Adjusted Revenue Works

In Medicare Advantage, the CMS payment to a health plan — and ultimately to the provider organization under a risk arrangement — is determined by the risk-adjusted premium. This premium is calculated by multiplying the regional benchmark rate by the patient’s RAF score. The RAF score is derived from documented HCCs submitted on claims during the prior calendar year.

#### The MA Payment Formula

CMS benchmark payment per member per month (approximately \$900–\$1,200 for a typical MA market) × patient RAF score = risk-adjusted payment. A patient with RAF 1.0 receives the benchmark. A patient with RAF 1.40 receives 40% above benchmark. A patient with RAF 0.80 receives 20% below benchmark. Every 0.10 RAF point represents approximately \$1,000 in annual revenue per patient. A panel of 1,000 patients with average RAF 0.10 below what their clinical complexity warrants loses approximately \$1,000,000 annually.

### 4.3 ACO REACH: How Shared Savings Works

Under CMS ACO REACH and similar ACO models, the organization receives traditional Medicare fee-for-service revenue plus a share of any savings achieved below the benchmark total cost of care. The benchmark is typically set based on the prior year’s costs, adjusted for RAF score changes. This means that accurate RAF documentation simultaneously increases the risk-adjusted benchmark (making it easier to achieve savings) and improves quality-adjusted performance.

- Higher RAF scores raise the benchmark, creating more headroom to achieve shared savings without reducing appropriate care
- Lower total cost of care — achieved through outmigration reduction, care management, and avoidable admission prevention — increases the savings percentage
- Higher quality scores increase the share of savings the organization retains
- Attribution retention ensures that savings achieved through care coordination are credited to the practice rather than a competing provider

#### 4.4 The MLR Standard and Its Operational Meaning

Medical Loss Ratio (MLR) is the percentage of premium revenue spent on direct patient care. CMS requires MA plans to maintain an MLR of at least 85% — meaning at least \$0.85 of every premium dollar must go to patient care. For provider organizations operating under risk contracts, MLR reflects the efficiency of care delivery.

MLR Level	Interpretation	Operational Response
<b>MLR &gt; 90%</b>	Costs exceeding sustainable level; shared savings at risk	Identify high-cost patients; improve care management; reduce OON utilization
<b>MLR 85–90%</b>	Above benchmark; monitor closely	Targeted outmigration reduction; CCM enrollment for high-risk patients
<b>MLR 80–85%</b>	At or near target; sustainable	Maintain care coordination discipline; protect attribution
<b>MLR &lt; 80%</b>	Strong performance; potential for shared savings	Expand program; replicate workflows; pursue enhanced VBC contracts

## Section 5: Integrated RAF + MLR Optimization Strategy

The following six operational components define the integrated strategy for simultaneously improving RAF accuracy, reducing MLR variance, retaining attributed lives, and achieving shared savings without increasing physician burden. Each component builds on the others — they are designed to operate as a unified system, not as independent initiatives.

### Component 1: Targeted Scheduling to Accelerate Attribution and Close RAF Gaps

The scheduling function is the first operational lever for RAF improvement. Before documentation can improve, patients must be seen. The following patient categories represent the highest-priority scheduling targets:

- High MLR + low RAF patients — the immediate financial priority
- New patients and patients not seen within 12 months — attribution validation and initial HCC capture
- ED and inpatient utilizers — TCM visit scheduled within 7–14 days of discharge
- Patients with outmigration or incorrect attribution — re-engage and correct attribution during intake
- Patients with incomplete AWWs or open chronic condition documentation gaps

Patient attribution is corrected during intake through patient portal activation and primary care selection, with quarterly reconciliation of attribution adds and terminations coordinated with the payer and CMS as applicable.

### Component 2: Embedded Support Teams for Pre-Visit Preparation

Successful RAF capture begins before the physician enters the room. Pre-visit chart preparation by embedded MA or care coordinator staff is the highest-leverage workflow change available to a primary care practice.

Pre-Visit Chart Preparation Item	Owner	Timing
Prior year HCCs requiring recapture	Navigator / MA	72 hours before visit
Suspect conditions from pharmacy and lab data	Analyst / Navigator	72 hours before visit
HEDIS and QIP care gaps	MA / Care Coordinator	72 hours before visit
Medication reconciliation draft	Pharmacist / MA	Day before visit
ED and hospital use summary for TCM coordination	Care Coordinator	Day before visit
Required screenings (PHQ-9, fall risk, SDOH)	MA / LPN	During rooming

**Embedded Team Redeployment**

Audio-only AWV staff performing low-productivity remote visits represent a significant redeployment opportunity. Embedded directly into the practices with the highest MLR variance, these individuals can perform in-person AWVs, schedule follow-up appointments, compile problem lists, and provide patients with orders for QIP metrics — creating substantially more clinical and financial value than remote audio-only encounters.

**Component 3: AWV Execution with Bundled Revenue**

AWV Revenue Component	Code	Medicare Rate	Requirement
Subsequent Annual Wellness Visit	G0439	\$58–94	Annual; HRA completed; problem list reviewed
Same-day E/M with modifier 25	99214	\$74	Separately identifiable problem; MEAT documented
Longitudinal complexity add-on	G2211	\$13	Ongoing relationship; primary care responsibility
Depression screening	G0444	Included	PHQ-9 administered; result documented
Obesity counseling	G0447	\$24	BMI $\geq$ 30; 5–15 min counseling
Advance care planning	99497	\$86	When personally performed; documented discussion
<b>Optimized AWV encounter total</b>	<b>Multiple codes</b>	<b>\$300–\$400</b>	vs < \$200 for AWV alone without E/M pairing

**Component 4: HCC Documentation Standards**

- Chronic conditions must be assessed, documented with MEAT criteria, and submitted every calendar year — prior-year carryforward does not count
- ICD-10 specificity is required: CKD stage, diabetes complication type, heart failure classification, depression severity and recurrence, laterality
- 837-B supplemental files submitted weekly to capture diagnoses beyond the 12-code CMS-1500 limit
- EMR Best Practice Advisories and HCC flags surface documentation opportunities at the point of care without requiring additional physician research

**Component 5: MLR Variance as a Precision Targeting Strategy**

High MLR + Low RAF patients reliably reflect: incomplete chronic condition documentation, high out-of-network utilization, incorrect or drifted attribution, missed AWVs, unclosed care gaps, and high-cost pharmacy or medical drug utilization that signals undocumented HCCs.

**The Simultaneous Fix**

Addressing documentation and care coordination for High MLR / Low RAF patients simultaneously reduces costs (through better care management) and increases revenue (through accurate RAF documentation). This dual improvement is what makes this population the highest-return intervention target in the entire attributed panel.

**Component 6: Physician Engagement Through Transparent Performance Dashboards**

Physicians respond positively to specific, visual, provider-level performance data when it is framed as an opportunity rather than a compliance requirement. Dashboards should display:

- RAF potential versus RAF captured — showing the specific revenue gap in dollar terms
- HCCs documented in clinical notes versus HCCs actually coded and submitted
- Care gaps per patient with the specific quality measure and patient name
- Attribution status and leakage metrics showing patients who have drifted to external providers
- Year-over-year performance comparison to demonstrate cumulative improvement

## Section 6: Financial Impact and Shared Savings Model

### 6.1 The Cost of Missed RAF Documentation

Scenario	RAF Points Missed	Annual Revenue Loss per Patient	Panel Impact (1,000 patients at 20%)
Chronic conditions documented but not coded	0.80–1.40	\$8,000–\$16,800	\$1.6M–\$3.4M
Acute-only coding; chronic conditions ignored	1.20–1.80	\$12,000–\$21,600	\$2.4M–\$4.3M
Problem list not reconciled annually	1.20–1.60	\$12,000–\$19,200	\$2.4M–\$3.8M
No supplemental 837-B submissions	0.30–0.60	\$3,000–\$7,200	\$600K–\$1.4M

### 6.2 Shared Savings Impact: What Full Integration Achieves

Strategic Action	Revenue Impact	Cost Impact	Net Shared Savings Impact
RAF documentation correction	+ \$10–12K per RAF point per patient	Neutral	Raises benchmark; increases savings headroom
AWV + E/M pairing	+ \$100–200 per encounter	Neutral	Quality gap closure; Star Rating improvement
CCM enrollment for eligible patients	+ \$24–60/month per patient	Reduces avoidable ED and readmission	Direct savings contribution
TCM capture post-discharge	+ \$82–119 per event	Reduces 30-day readmission	Avoidable admission cost reduction
Outmigration reduction (5%)	+ \$2,500 downstream per retained patient	Utilization management captured	In-network cost management applied
Attribution correction	Secures full risk-adjusted payment	Eliminates cost without credit	Aligns cost and revenue accountability

## Appendix: Professional Terminology Reference Guide

The following reference guide defines the key terms used across managed care, value-based care, risk adjustment, revenue cycle management, population health, and operational leadership. This guide is designed for clinical and operational staff entering value-based care environments and for leadership teams seeking a shared vocabulary for performance management conversations.

<b>I. MANAGED CARE FUNDAMENTALS</b>	
<b>Managed Care</b>	A healthcare delivery model that integrates financing and care delivery to manage cost, utilization, and quality. Includes HMO, PPO, EPO, and POS plan structures.
<b>Payer</b>	An entity that finances healthcare services — commercial insurers, Medicare, Medicaid, and self-insured employer groups.
<b>Network</b>	A contracted group of providers delivering services to plan members at negotiated rates.
<b>In-Network vs. Out-of-Network</b>	Contracted providers (in-network) versus non-contracted providers (out-of-network) with different cost-sharing and reimbursement structures. Out-of-network use in a VBC arrangement is a leakage event.
<b>Capitation</b>	Fixed per-member-per-month payment for a defined set of services regardless of actual utilization. Transfers financial risk to the provider.
<b>PMPM (Per Member Per Month)</b>	Monthly payment amount paid for each enrolled member regardless of service utilization.
<b>Utilization Management (UM)</b>	Process to evaluate medical necessity, level of care, and appropriateness of services before, during, or after care delivery.
<b>Prior Authorization (PA)</b>	Pre-approval required from the payer before certain services are performed. Denial of authorization is a leading cause of claim denials.
<b>Shared Savings</b>	Provider participation in savings achieved when total cost of care falls below the actuarial benchmark. The organization retains a defined percentage of the savings.
<b>Shared Risk</b>	Arrangement where providers share in both savings below benchmark and losses above benchmark. Higher risk; higher potential return.
<b>Stop Loss</b>	Protection against catastrophic claims exceeding a defined threshold, limiting downside risk in capitated or risk-based arrangements.
<b>II. VALUE-BASED CARE (VBC)</b>	
<b>Value-Based Care (VBC)</b>	Care delivery model linking reimbursement to quality outcomes and cost efficiency rather than service volume. Encompasses a continuum from pay-for-performance to full global capitation.
<b>Alternative Payment Model (APM)</b>	Payment structures that move away from traditional fee-for-service toward risk-sharing, quality-linked, or episode-based payment.
<b>Accountable Care Organization (ACO)</b>	Provider organization accountable for total cost and quality of care for an attributed patient population. Earns shared savings when costs fall below benchmark.

<b>Clinically Integrated Network (CIN)</b>	Physician-led network coordinating care under shared quality metrics, data infrastructure, and governance. Supports referral retention and population health management.
<b>Attribution</b>	Assignment of patients to a specific provider or organization for cost, quality, and revenue accountability. Attribution drives which organization receives risk-adjusted payment.
<b>HEDIS</b>	Healthcare Effectiveness Data and Information Set. Standardized quality measures used by health plans for Star Ratings and quality bonuses.
<b>Star Ratings</b>	CMS quality rating system for Medicare Advantage plans. Higher stars = higher quality bonuses. Affected by HEDIS measures, patient experience, and access.
<b>Bundled Payment</b>	Single payment covering all services for an episode of care (e.g., hip replacement), distributed across providers involved in the episode.

### III. RISK ADJUSTMENT AND RAF/HCC

<b>Risk Adjustment Factor (RAF)</b>	Score reflecting predicted healthcare costs based on documented diagnosis burden. Higher RAF = higher risk-adjusted payment. Used in Medicare Advantage and ACO REACH.
<b>Hierarchical Condition Category (HCC)</b>	CMS risk adjustment model grouping related diagnoses into condition categories that predict future healthcare cost. Multiple HCCs can be captured per patient.
<b>CMS-HCC</b>	The specific Medicare Advantage risk scoring methodology maintained by CMS. Transitions from v24 (2024) to v28 (2025) to v29 (anticipated 2026).
<b>MEAT Documentation</b>	Monitor, Evaluate, Assess, Treat — the documentation standard CMS requires for a condition to count toward RAF. Generic problem list carryforward does not satisfy MEAT.
<b>Medical Loss Ratio (MLR)</b>	Percentage of premium revenue spent on direct medical claims. CMS requires MA plans to maintain at least 85% MLR. For provider organizations, MLR measures care efficiency.
<b>Total Cost of Care (TCOC)</b>	Aggregate cost for all services delivered to an attributed patient population. Benchmark in ACO and shared savings arrangements.
<b>Prospective Risk Adjustment</b>	Using prior-year documented diagnoses to set the current-year payment. Emphasizes annual recapture of all active chronic conditions.
<b>Supplemental Data (837-S)</b>	Supplemental claim file submitted outside standard 837P claims, used to capture additional HCC diagnoses beyond the 12-code CMS-1500 limit.

### IV. REVENUE CYCLE MANAGEMENT (RCM)

<b>Charge Capture</b>	Recording and submitting all services rendered for billing. Gaps in charge capture are direct revenue losses.
<b>Clean Claim Rate</b>	Percentage of claims accepted on first submission without edits or denials. High-performing practices achieve > 95%.
<b>Days in AR (DAR)</b>	Average number of days to collect payment from date of service. Benchmark: < 35 days for physician practices.
<b>Net Collection Rate (NCR)</b>	Percentage of collectible revenue actually collected after contractual adjustments. Target: > 95%.

<b>Denial Rate</b>	Percentage of submitted claims denied by payers. HFMA benchmark: < 8% total; < 5% authorization denials.
<b>First Pass Resolution Rate (FPRR)</b>	Percentage of claims paid on first submission without rework. High-performing: > 90%.
<b>Contractual Adjustment</b>	Difference between billed charge and payer-allowed amount per contract. Not collectible from the patient under participating agreements.
<b>Write-Off</b>	Adjustment removing uncollectible revenue from accounts receivable. Administrative write-offs require director approval and root-cause documentation.
<b>wRVU (Work RVU)</b>	Work relative value unit measuring physician effort and complexity. Basis for most physician compensation models. Should be reconciled to collectible, not billed, claims.

## V. POPULATION HEALTH AND CARE MANAGEMENT

<b>Care Gap</b>	A missing preventive or chronic care service that should have been delivered based on clinical guidelines or payer quality requirements.
<b>CCM (Chronic Care Management)</b>	Monthly care management program for patients with two or more chronic conditions. Requires 20+ minutes of care management per month. Billed as 99490 / 99491.
<b>TCM (Transitional Care Management)</b>	Post-discharge coordination services within 7 or 14 days of hospital or SNF discharge. Significantly higher reimbursement than standard E/M. Billed as 99495 or 99496.
<b>Risk Stratification</b>	Categorizing patients by predicted utilization and cost to prioritize care management, outreach, and intervention resources.
<b>Social Determinants of Health (SDOH)</b>	Non-medical factors influencing health outcomes: housing instability, food insecurity, transportation barriers, social isolation. Screened via Z-codes.
<b>Remote Patient Monitoring (RPM)</b>	Technology-based physiologic tracking for conditions such as hypertension, heart failure, and diabetes. Billable program supporting RAF and quality improvement.
<b>AWV (Annual Wellness Visit)</b>	Medicare preventive visit using G0438 (initial) or G0439 (subsequent). No co-payment. Anchors RAF capture, HEDIS gap closure, and attribution stability.
<b>G2211</b>	Add-on complexity code for longitudinal primary care responsibility. Billed with E/M visits; captures cognitive burden of ongoing complex patient management.

## VI. CONTRACTING AND PAYER STRATEGY

<b>Fee Schedule</b>	Contracted reimbursement rates by CPT code between payer and provider. Basis for all claim payment calculations.
<b>Allowed Amount</b>	Maximum amount a payer will reimburse for a given service under the contract. Billed charges above the allowed amount are written off as contractual adjustments.
<b>Narrow Network</b>	Limited provider network designed to control cost through concentration of referrals and steerage. Requires strong in-network access to prevent leakage.

<b>Tiered Network</b>	Variable reimbursement or patient cost-sharing based on provider performance tier. High-performing, lower-cost providers receive preferred tier status.
<b>Global Budget</b>	Fixed total payment covering all services for a defined population during a contract period. Highest risk; highest savings opportunity.
<b>Direct Employer Contracting</b>	Employer directly contracts with provider group, bypassing commercial insurer. Increasingly common in large self-insured employer markets.

## VII. COMPLIANCE AND REGULATORY

<b>Stark Law</b>	Prohibits physician self-referral to entities with which the physician has a financial relationship unless an exception applies.
<b>Anti-Kickback Statute</b>	Prohibits any remuneration intended to induce or reward referrals of federally reimbursed healthcare services.
<b>False Claims Act</b>	Federal law prohibiting the submission of fraudulent claims to government payers. Whistleblower provisions create significant compliance risk.
<b>RAC (Recovery Audit Contractor)</b>	CMS-contracted auditors who identify improper Medicare payments and recover overpayments. Common targets: coding errors, global period violations, duplicate billing.
<b>CMS 1500</b>	Standard professional claim form used to bill Medicare, Medicaid, and most commercial payers for physician and outpatient services.

## VIII. OPERATIONAL LEADERSHIP TERMS

<b>Leakage</b>	Referral or revenue leaving the network to external providers. In VBC, leakage also represents lost RAF capture and care coordination.
<b>Attribution Reconciliation</b>	Quarterly validation of assigned patient panels to identify incorrect attribution, lapsed enrollment, or patients seen by competing providers.
<b>Network Integrity</b>	Ensuring that referrals, diagnostics, and specialty care remain within the clinically integrated network. Measured by in-network referral completion rate.
<b>Throughput</b>	Efficiency of patient flow through a clinical encounter — from check-in through rooming, visit, checkout, and referral scheduling.
<b>Provider Compensation Model</b>	Framework linking physician productivity, quality performance, and VBC metrics to compensation. RAF-aligned models should reconcile to collectible, not billed, wRVUs.
<b>Incentive Pool</b>	Funds allocated for quality and cost performance, distributed based on achievement of defined metrics including Star Ratings, HEDIS closure rates, and RAF targets.

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