KONTIKI STRATEGIC HEALTH ADVISORS

# Value-Based Care Strategy and CIN Operational Execution

A Unified Framework for RAF Capture, MLR Reduction, Attribution Retention, CIN Leakage Control, and 90-Day Shared Savings Acceleration

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# Executive Summary

Healthcare organizations operating in value-based care environments face a structural financial challenge that cannot be solved by working harder. The revenue that sustains a Medicare Advantage or ACO practice is determined by the accuracy of clinical documentation, the discipline of care coordination, and the operational integrity of workflows that span analytics, scheduling, clinical encounters, referral management, and revenue cycle execution.

This white paper presents a unified operational framework across two interconnected disciplines. Part One establishes the strategic foundation for RAF capture, MLR reduction, and attribution retention through structured documentation, MEAT-compliant coding, and proactive HCC gap closure. Part Two translates that strategy into a concrete, eight-swimlane CIN workflow and a 90-day operational sprint that produces measurable financial results within a single quarter.

**Unified Framework Premise**

Accurate RAF capture, attribution stability, and specialty leakage control are not separate programs. They are the same operational discipline executed consistently at the point of care. When analytics identifies the right patients, scheduling gets them to their PCP, the care team prepares the chart, the physician documents with specificity, and the referral hub closes the loop where every discipline produces its result simultaneously as a CIN. RAF capture is not simply a financial exercise; it is a strategic clinical and operational framework designed to identify patients with the highest acuity, chronic disease burden, and social determinants risk so they can be proactively managed within an integrated care continuum. High-performing health systems use RAF analytics to ensure patients have timely access to primary care, specialty care, and an appropriate cadence of longitudinal visits that support concurrent and prospective management, reducing avoidable emergency department utilization, unnecessary readmissions, fragmentation, and outmigration. When coupled with well-designed Chronic Care Management (CCM), Transitional Care Management (TCM), and Transition of Care (TOC) programs, patients experience stronger continuity, engagement, and trust in the system, increasing both clinical stability and retention within the network. Outmigration is therefore not merely a revenue concern; it is a continuity-of-care failure that disrupts coordinated management, delays interventions, and weakens patient outcomes. Organizations that view RAF solely as a reimbursement metric miss the broader purpose. Assessing patient acuity alongside SDoH enables providers to integrate patients into a clinically aligned, team-based delivery model that reflects true best practices in value-based healthcare.

**$2M–$3.4M**
Annual RAF revenue recoverable per 1,000-patient panel with 20% missed HCC rate

**$77M**
Total incremental annual impact across 150,000 MA lives (AWV, TCM, CCM, leakage reduction)

**90 days**
Time to measurable RAF lift, CCM revenue, and MLR stabilization from 500-patient sprint

**>85%**
In-network referral completion target and AWV completion target for high-performing panels

PART ONE

# Value-Based Care Strategy

*RAF Capture, MLR Management, and Attribution Retention*

## Section 1: Strategic Framework for Complete RAF Capture

Capturing accurate and complete RAF scores requires unified effort across operations, clinical teams, revenue cycle management, and analytics. RAF reflects the true clinical complexity of a patient population and drives appropriate reimbursement in Medicare Advantage, CMS ACO REACH, and all risk-based contractual arrangements. Incomplete documentation does not simply reduce quality scores; it creates a measurable, compounding revenue gap that worsens year over year.

### 1.1 The RAF Revenue Gap

**Financial Reality**

For a physician panel of 1,000 patients, if 20% (200 patients) have missed RAF conditions averaging 1.0–1.4 RAF points each, and the financial value per RAF point is $10,000–$12,000, the estimated annual revenue loss is $2,000,000 to $3,360,000. This is a correctable gap.

### 1.2 Accelerating Value for Every 10,000 Medicare Advantage Patients

For every 10,000 Medicare Advantage patient lives, financial success in value-based contracts is driven by three controllable levers: accurate RAF capture, disciplined MLR management, and stable patient attribution. When AWVs are appropriately paired with E/M and preventive add-on codes, organizations unlock material revenue, reduce downstream utilization, and expand access for new Medicare-eligible patients.

| Financial Lever | Assumptions | Annual Value |
|---|---|---|
| AWV capture at 85% (127,500 lives) | $300 average bundled visit value with E/M, G2211, preventive screenings | **$38.3M** |
| Early AWV incentive (Jan–June) | $75 incentive on 60% of completed AWVs | **$5.7M** |
| Transitional Care Management | 20% eligibility, 60% capture rate | **$6.1M** |
| Chronic Care Management | 30% eligibility, 50% capture rate | **$8.4M** |

| | | |
|---|---|---|
| Reduced out-migration | 5% reduction at $2,500 net downstream value per retained patient | **$18.8M** |
| **Total incremental annual impact** | **Conservative model across 150,000 MA lives** | **$77M** |

## 1.3 The RAF–MLR Relationship: The Car Insurance Analogy

RAF reflects clinical complexity and determines the revenue needed to care for a patient. When RAF is incomplete, payments underestimate the true acuity of the population and the cost of managing chronic disease.

> **The Car Insurance Model**
> A patient is like a car insured for repairs. RAF = the car's condition and risk profile. A car with more issues receives a higher repair budget. MLR = the percent of the budget actually spent on repairs. If repair costs are high but the car's risk score is low, the repair shop loses money. Low RAF + high MLR = high cost and low reimbursement — the worst possible financial outcome in value-based care.

| Quadrant | RAF | MLR | Interpretation | Priority Action |
|---|---|---|---|---|
| Optimal | High | Low | Well-documented, well-managed complex panel | Sustain and replicate |
| **Under-coded** | Low | High | High cost, incomplete documentation — highest return target | Immediate RAF + care mgmt action |
| Complex gap | High | High | Complex panel with incomplete care coordination | Strengthen care management |
| Simple panel | Low | Low | Low-acuity panel; lower VBC value | Grow complexity, expand AWVs |

## 1.4 Core RAF Capture Levers

### Annual Wellness Visits as the RAF Anchor

- AWVs are the structured annual opportunity to review the problem list, identify all active chronic conditions and SDoH, and document HCC-adjusted ICD-10 codes with proper specificity
- Target AWV completion rate: 85% or greater for a Medicare Advantage population
- AWV completion rate is the leading indicator of RAF performance; organizations above 85% consistently outperform peers on risk-adjusted revenue
- AWVs can include depression screening, alcohol misuse screening, obesity counseling, advance care planning, and tobacco cessation; each generating incremental revenue while closing HEDIS gaps

### MEAT Documentation Standards

**What MEAT Requires at Every Visit**

Monitor: tracking test results, treatment response, or symptom changes. Evaluate: Reviewing current status, lab data, imaging, or clinical findings. Assess: Documenting the condition's current state and its impact on the patient. Treat: Prescribing, adjusting medications, ordering tests, or making referrals. Generic problem list carry-forward does not satisfy MEAT criteria and will not count toward RAF.

### ICD-10 Specificity Under CMS-HCC v28

| Condition | Incomplete (v24 accepted) | Complete (v28 required) | RAF Impact |
|---|---|---|---|
| Type 2 Diabetes | E11.9 — without complication | E11.22 — with CKD Stage 3 (+ N18.3) | High |
| Hypertension + CKD | I10 — Hypertension | I12.9 — Hypertensive CKD Stage 1–4 (+ N18.4) | High |
| Depression | F32.9 — unspecified | F33.1 — MDD recurrent, moderate | Moderate |
| Heart Failure | I50.9 — unspecified | I50.22 — systolic, chronic | High |
| COPD | J44.1 — with exacerbation | J44.1 + associated respiratory failure | Moderate |

## 1.5 PCP Value Proposition: wRVUs Without Additional Work

This model is intentionally designed to increase PCP wRVUs while decreasing administrative burden and cognitive overload. It anchors care delivery around a well-prepared AWV, supported by team-based pre-visit work, so the physician's time is spent exclusively on diagnosis, treatment, and medical decision-making focused on the patient's access needs and clinical outcomes.

| Code | Description | wRVUs (2026) | Strategic Value |
|---|---|---|---|
| G0439 | Subsequent Annual Wellness Visit | 1.50 | Attribution anchor, RAF capture, no patient cost-sharing |
| 99214-25 | Established patient E/M (same day) | 1.92 | Chronic condition management, MDM documented |
| G2211 | Longitudinal primary care complexity | 0.33 | Captures the cognitive burden of complex patients |
| 99497 | Advance care planning | 1.50 | When personally performed, high value, high patient impact |

| | | | |
|---|---|---|---|
| G0447 | Obesity counseling | 0.18 | Preventive, quality measure, minimal time |
| **Optimized visit total** | **AWV + E/M + G2211 + add-ons** | **3.75–5.43+** | vs. 1.30 for 99213-only visit |

## 1.6 Supplemental Claims and the 837-B Strategy

A CMS-1500 claim form accommodates only 12 diagnosis codes. Complex patients with multiple active chronic conditions routinely exceed this limit, creating an invisible documentation gap where conditions are present in the record but never submitted for risk adjustment.

- 837-B supplemental files allow organizations to submit validated additional diagnoses documented at the encounter but not included on the claim
- High-performing groups submit supplemental files weekly to ensure full HCC capture across their attributed population
- Organizations that implement this process systematically recover meaningful RAF revenue without adding clinical documentation burden

## 1.7 HCC Model Evolution: 2024–2026

| Year | Model | Key Change | Organizational Risk |
|---|---|---|---|
| 2024 | CMS-HCC v24 | Broader HCC categories; higher weights for common conditions | Baseline — organizations familiar with this model |
| 2025 | CMS-HCC v28 | Many HCCs removed or consolidated; specificity now required | **High — 10–20% RAF erosion without action** |
| 2026 | CMS-HCC v29 (anticipated) | Expanded behavioral health capture; updated SDoH Z-code mappings | **Moderate — BH workflow gaps will surface** |

# Section 2: MLR Variance and Attribution Retention Strategy

Medical Loss Ratio variance analysis reveals which patient segments are consuming disproportionate resources relative to their documented complexity. In value-based care, the organization that controls attribution controls the financial outcome. When patients are attributed, they migrate to external providers for specialty care, diagnostics, pharmacy, or behavioral health services, and the originating organization loses both the clinical coordination opportunity and the RAF capture that would result from those encounters. The goal should be clinical integration, coupled with continuity of care, shared within a single EMR instance.

## 2.1 Targeting the High-MLR / Low-RAF Population

**Target Population Definition**

RAF below 0.8 | Medical spend above $1,000 PMPM | No PCP visit in 6 months | No AWV within calendar year | Not enrolled in CCM or TOC | Exclude ESRD and active oncology. This cohort represents the highest-return intervention opportunity in the attributed population.

| Criterion | Definition | Rationale |
|---|---|---|
| RAF below 0.8 | Risk score below the MA benchmark average | Indicates an underdocumented disease burden relative to utilization |
| PMPM above $1,000 | Per-member per-month spend exceeds threshold | High cost without corresponding RAF = worst VBC financial outcome |
| No PCP visit in 6 months | No E/M with attributed PCP | Attribution drift risk (outmigration); HCC recapture opportunity missed annually |
| No AWV within 12-mns | Annual Wellness Visit not completed | RAF anchor event missed; HRA, HCC review, preventive gaps unaddressed |
| Not enrolled in CCM or TOC | No active care management | High-risk patients without oversight drive avoidable utilization |

## 2.2 Behavioral Health as an Underutilized RAF Lever

| ICD-10 Code | Diagnosis | RAF Category | Documentation Requirement |
|---|---|---|---|
| F33.1 | Major depressive disorder, recurrent, moderate | HCC 59 | Severity, recurrence, and treatment response documented |
| F32.9 | Depression, unspecified | Lower weight — use F33.1 when documented | Specify recurrence and severity |
| F41.1 | Generalized anxiety disorder | HCC 59 (anxiety spectrum) | MEAT documentation required annually |

| | | | |
|---|---|---|---|
| F31.9 | Bipolar disorder, unspecified | HCC 59 | Specify type and current episode |

- Bill G0444 for annual depression screening in Medicare patients
- Document remission status, severity, and recurrence; these determine the correct ICD-10 code and RAF weight
- Coordinate PCP follow-up within 30 days of any positive behavioral health screening

## 2.3 Leakage Control and In-Network Service Alignment

Outmigration is one of the most costly and least visible financial losses in value-based care. Controlling MLR and closing care gaps requires aligned utilization of system services across all categories:

- Inpatient and outpatient services with appropriate admission avoidance and length-of-stay management
- Pharmacy and infusion services for Part B drugs, specialty medications, and biologics (reintroduce buy-and-bill versus vendor-supplied where applicable) and coordinate within one EMR instance for better patient continuity
- DMEPOS management to reduce excess spend and leakage
- Physical, occupational, and speech therapy to prevent readmissions and functional decline
- Diagnostics, imaging, and laboratory services; ensure timely, appropriate testing and follow-up in-network
- Specialty referrals redirected to in-network providers with closed-loop scheduling before the patient leaves the practice to enhance patient access and help with care navigation and scheduling

> **Attribution Loss Calculation**
> A Medicare Advantage patient with an average RAF score of 1.2 and PMPM of $850 represents approximately $10,200 in annual risk-adjusted revenue. If 18% of a 1,750-patient panel migrates due to access delays or fragmented care, that represents 315 patients and approximately $3.2 million in annual at-risk revenue before accounting for quality bonus reductions.

## 2.4 Clinical Examples of Missed RAF Capture and Financial Impact

| Scenario | Conditions Documented | Full RAF Potential | RAF Captured | Annual Revenue Lost |
|---|---|---|---|---|
| Chronic conditions not coded | DM with CKD, CHF, COPD, MDD, PVD | ~1.79 | 0.25–0.35 | **$13,300–$16,800** |
| Acute issue only coded | SOB visit; COPD, CRF, AFib, CKD4, DM, obesity in record | ~2.20 | 0.30–0.40 | **$17,000–$21,600** |

| | | | | |
|---|---|---|---|---|
| Problem list not reconciled annually | DM angiopathy, CHF, COPD, CKD3a, PAD, anxiety | ~1.60 | ~0.20 | **$13,300–$16,800** |

| Panel Impact Assumption | Conservative | High Estimate |
|---|---|---|
| Panel size | 1,000 patients | 1,000 patients |
| % with missed RAF | 20% (200 patients) | 20% (200 patients) |
| Avg missed RAF per patient | 1.0 RAF points | 1.4 RAF points |
| Value per RAF point | $10,000 | $12,000 |
| **Annual RAF revenue loss** | **$2,000,000** | **$3,360,000** |

# Section 3: Workflow Architecture — Pre-Visit, Visit, and Post-Visit Standards

Sustainable RAF performance is not achieved through periodic audits or training. It requires an embedded daily operational workflow that spans analytics, scheduling, pre-visit preparation, the clinical encounter, and post-visit documentation reconciliation.

## 3.1 Pre-Visit QIP Preparation: The Highest-Leverage Workflow

The quality improvement planning review conducted before the patient arrives is the single highest-leverage step in RAF capture performance. When the chart is fully prepared before the visit, physician documentation accuracy and completeness improve significantly without adding clinical time. The problem list should be up to date, and problems should be active to focus on the patient's current clinical interventions.

- Review all open HCC gaps from the prior year and identify chronic conditions not yet documented in the current calendar year
- Flag AWV-eligible patients and confirm HRA is ready for completion during rooming; the physician should not enter the room until the HRA is complete
- Identify HEDIS and quality measure gaps: A1c, colorectal screening, breast cancer, nephropathy monitoring, foot exam, depression screening
- Document out-of-network utilization, open specialist and ancillary referrals, and care management enrollment eligibility
- Deliver a structured visit preparation summary to the provider before every encounter: HCC checklist, CCM eligibility, depression screening flag, and open quality gaps

> **Pre-Visit Completion Standard**
> Pre-visit QIP completion rate target: greater than 65% of eligible gap items addressed per visit. Best-in-class practices achieve 72–78%. This is a CMA-owned workflow, not a physician task. Source: MGMA 2024; NCQA HEDIS benchmarks.

## 3.2 During the Visit: Execution Standards

- Complete the Annual Wellness Visit/Health Risk Assessment: HRA, functional status, cognitive screening, fall risk, preventive review, personalized prevention plan
- Perform medically necessary E/M visit for active problems with modifier 25 applied; problem-oriented note must be distinct from AWV documentation
- Capture HCC-adjusted ICD-10 codes for every active chronic condition with MEAT documentation in the assessment and plan
- Perform depression screening (PHQ-9); document severity, recurrence, and treatment response when positive
- Enroll eligible patients in CCM or TCM during the visit — do not defer enrollment to a follow-up call
- Review all specialty utilization with the patient; redirect out-of-network referrals to in-network providers with a real-time referral order before the patient leaves

## 3.3 Checkout and Closed-Loop Referral Management

- No referral order leaves the practice without a scheduled appointment confirmed before the patient exits the building
- Schedule all specialist appointments, diagnostic tests, and laboratory orders in-network before checkout
- The referral hub confirms appointments within 24–48 hours and contacts the patient if an appointment was not kept
- Track four metrics per referral: ordered, scheduled, completed, and externally completed — the last category drives immediate intervention
- Target: greater than 85% of specialty referrals completed within the network by Day 90

## 3.4 Transitional Care Management: Non-Negotiable Revenue

TCM visits pay significantly more than standard E/M visits, reduce readmissions and ED utilization, and reinforce medication adherence and care plans. For every 10,000 patients, missed TCM opportunities represent both lost revenue and avoidable costs. Capturing TCM stabilizes high-risk patients and protects shared savings.

| TCM Code | Contact Requirement | Visit Window | wRVU | Medicare Rate |
|---|---|---|---|---|
| 99495 | Contact within 2 business days | Face-to-face within 14 days | 2.11 | $82 |
| 99496 | Contact within 2 business days | Face-to-face within 7 days | 3.07 | $119 |

PART TWO

# CIN Attribution and Leakage Control

*Eight-Swimlane Workflow and 90-Day Operational Sprint*

## Section 4: Target Population Strategy

The fastest financial and quality improvement lever available to a primary care network is the patient who has documented clinical complexity but whose care is undercoded, unmanaged, or fragmented. These patients carry high medical costs while generating inadequate risk-adjusted revenue to offset them.

### 4.1 Cohort Criteria and Stratification

| Criterion | Definition | Rationale |
|---|---|---|
| RAF below 0.8 | Risk score below MA benchmark | Underdocumented disease burden |
| PMPM above $1,000 | Monthly spend exceeds threshold | High cost + low RAF = worst VBC outcome |
| No PCP visit in 6 months | No E/M with attributed PCP | Attribution drift and HCC recapture risk |
| No AWV this year | AWV not completed in current calendar year | RAF anchor event missed |
| Not enrolled in CCM or TOC | No active care management program | High-risk without oversight drives avoidable utilization |
| **Exclude ESRD and active oncology** | Cost driven by clinical complexity | Require disease management, not RAF correction |

**Ultra-High-Priority Targeting**

Patients with RAF below 0.4 and annual spend above $12,000 represent the highest-return intervention targets. Everyone who is successfully re-engaged in primary care, re-documented, and enrolled in care management produces measurable ROI within a single quarter.

### 4.2 Cohort Expansion Sequence

| Wave | Cohort | Size | Focus |
|---|---|---|---|
| Wave 1 | Initial high-priority cohort | 500 patients | RAF < 0.8, PMPM > $1,000, no AWV, no PCP 6 months |
| Wave 2 | Behavioral health without PCP | Next 500 | Active BH diagnosis, no PCP E/M in 12 months |
| Wave 3 | Out-of-network cardiology/endo | Next 500 | External specialty claims, no in-network PCP coordination |
| Wave 4 | Full panel expansion | Remaining attributed | Scale proven model across entire MA population |

## Section 5: Eight-Swimlane End-to-End Workflow

The following workflow defines operational accountability across each functional team involved in attribution recovery and RAF capture. Each swimlane has a defined trigger, defined outputs, and defined escalation paths. No patient moves from one lane to the next without the prior lane completing its deliverable.

**SWIMLANE 1 ANALYTICS AND POPULATION HEALTH**

**Identify Target Cohort**

→ Pull 500 patients: RAF < 0.8 | PMPM > $1,000 | No PCP 6 months | No AWV this year | Not in CCM or COC | Exclude ESRD and oncology

**Risk-Stratify by Utilization Pattern**

- Cardiology utilization (out-of-network first, then in-network)
- Endocrinology utilization (diabetic patients with external endo claims)
- Behavioral health diagnosis (active BH without recent PCP visit)

**Push Daily Worklist**

→ Deliver prioritized patient list to PCP office scheduling and care management teams daily

→ Continue identifying next 500-patient cohort in parallel

**SWIMLANE 2 PCP OFFICE OUTREACH AND SCHEDULING**

**Outreach Team Contacts Patient**

→ Scheduling script: “Annual wellness and medication review needed with your physician”

**Schedule Combined Visit**

- AWV + E/M same day in extended visit slot
- If QIP gaps exist: coordinate AWV 3–5 days prior, schedule E/M at 31–61 days to allow gap closure first
- Confirm patient is enrolled in patient portal; assist with enrollment if not

**If Patient Refuses**

- Escalate to care manager | Document refusal | Reattempt within 30 days

***Execution target: 80% of cohort scheduled within 30 days***

## SWIMLANE 3 PRE-VISIT QIP REVIEW

### Pre-Visit Chart Preparation (72 hours before appointment)

- Identify all open HCC gaps from prior year
- Identify chronic conditions not documented in current calendar year
- Document out-of-network utilization: ED visits, inpatient admissions, specialist claims
- Review all open and incomplete specialist referrals
- Identify HEDIS and quality measure gaps: A1c, colorectal, mammogram, nephropathy, foot exam

### Generate Visit Preparation Summary for Provider

- HCC checklist | CCM eligibility status | Depression screening flag | Open quality gaps
- Clean up problem list: resolve outdated or inactive conditions

## SWIMLANE 4 PCP VISIT EXECUTION

### During the Visit

1. Complete Annual Wellness Visit: HRA, prevention plan, cognitive screen, fall risk
2. Perform medically necessary E/M for active chronic conditions (modifier 25 if same day as AWV)
3. Capture HCC-adjusted ICD-10 codes for every active chronic condition with MEAT documentation
4. Perform depression screening (PHQ-9) if indicated; document severity, recurrence, treatment status
5. Enroll eligible patients in CCM or COC during the visit — do not defer to a follow-up call
6. Reconcile medications: adherence gaps, formulary issues, high-risk medications
7. Review specialty utilization; redirect out-of-network referrals to in-network providers

### If Specialty Referral Needed

→ Select in-network specialist → Place referral order before patient leaves → Checkout schedules appointment before patient exits

## SWIMLANE 5 CHECKOUT AND CLOSED-LOOP SCHEDULING

### Before the Patient Leaves the Building

- Schedule all specialist appointments in real time at checkout
- Schedule all diagnostic tests and laboratory orders in-network
- Print appointment confirmation and provide to patient before exit
- Initiate prior authorization for services requiring pre-certification
- Send referral documentation to specialist, including MEAT documentation for coding support

### Non-Negotiable Standard

→ No referral order leaves the practice without a scheduled appointment confirmed. Zero exceptions.

## SWIMLANE 6 REFERRAL HUB CONFIRMATION

### Within 24–48 Hours of Each Visit

- Confirm appointment booked in specialist system
- Track prior authorization status for all ordered services
- Contact patient if appointment was not confirmed or kept
- Escalate all unbooked referrals to practice administrator

### Track Four Metrics per Referral

- Ordered | Scheduled | Completed | External (leakage event)

***Target: > 85% of referrals completed in-network by Day 90***

## SWIMLANE 7 CARE MANAGEMENT ACTIVATION

### If Patient is Eligible

- Enroll in CCM (2+ chronic conditions, 20+ minutes monthly)
- Enroll high-risk patients in TCM if recently discharged
- Initiate RPM for heart failure or uncontrolled diabetes if applicable
- Schedule follow-up touchpoints: 30-day post-enrollment, monthly CCM call

### Target

→ > 40% CCM enrollment rate among eligible patients in target cohort by Day 60

## SWIMLANE 8 PERFORMANCE MONITORING

### Weekly Dashboard Review

- AWV completion rate vs. 70-85% target
- RAF lift per patient vs. baseline
- % of cohort with at least one HCC captured or recaptured
- CCM enrollment rate vs. 40% target
- In-network referral completion rate vs. 85% target
- PMPM trend in target cohort vs. baseline

### Expansion Trigger

→ Once Wave 1 targets are met, activate Wave 2 and continue rolling 500-patient expansion

# Section 6: 90-Day Operational Sprint

The 90-day sprint is structured as three operational phases, each with defined deliverables, execution targets, and accountable roles. The sprint generates proof of concept on the initial 500-patient cohort before scaling to the full attributed population.

## PHASE 1 Days 1–30 — Identify, Activate, and Schedule

8. Pull 500-patient target file meeting all RAF, PMPM, visit history, and program enrollment criteria. Begin identifying the next 500 in parallel.
9. Exclude ESRD and active oncology from the target file.
10. Risk-stratify by out-of-network cardiology and endocrinology utilization first, then in-network high-utilization.
11. Assign outreach teams and initiate scheduling calls. Coordinate AWV timing relative to QIP gap visits per the scheduling logic above.
12. Confirm all scheduled patients are enrolled in the patient portal; assist with enrollment for unenrolled patients.
13. Complete pre-visit HCC gap review for each scheduled patient 72 hours before the appointment.
14. Clean up problem list for all target patients before the visit: resolve outdated, duplicate, or inactive conditions.
15. Pull behavioral health patient list and begin Wave 2 outreach preparation.
16. Identify all out-of-network cardiology and endocrinology claims for redirection planning.

**Execution Targets**

- 80% of cohort scheduled within 30 days
- Behavioral health patient list pulled and outreach initiated
- Out-of-network specialty claims identified and flagged for redirection
- All scheduled patients confirmed in patient portal

## PHASE 2 Days 31–60 — Visit Completion and RAF Capture

17. Complete AWV + E/M combination visits for all scheduled patients in the cohort.
18. Capture HCC-adjusted ICD-10 codes for every active chronic condition with MEAT documentation at every visit.
19. Enroll all eligible patients in CCM and TCM during the visit.
20. Redirect cardiology and endocrinology referrals to in-network providers. Provide specialist with MEAT documentation and coding support before the appointment.
21. Schedule joint meeting with specialty practice leadership to align in-network referral protocols.
22. Launch depression screening and documentation workflow for all BH-flagged patients.
23. Begin weekly 837-B supplemental submissions for complex encounters with more than 12 active diagnoses.
24. Distribute bi-weekly RAF lift scorecards to providers showing baseline versus current RAF and HCC capture progress.

**Execution Targets**

- 60% of total cohort visits completed by Day 60
- RAF lift documented and reported to leadership
- 40% CCM enrollment rate among eligible patients
- 75% of specialty referrals redirected in-network

## PHASE 3 Days 61–90 — Close Loop, Audit, and Scale

25. Complete all remaining visits from the initial 500-patient cohort.
26. Confirm all outstanding specialty referrals have been scheduled and completed in-network.
27. Audit RAF documentation accuracy across all completed visits with coder review.
28. Track PMPM trend shift in the target cohort against baseline.
29. Produce 90-day results summary for leadership: RAF lift, CCM enrollment, in-network referral performance, PMPM trend.
30. Expand model to next wave of patients, including community health center populations with high MA enrollment and low RAF.
31. Update provider-level scorecards with year-over-year RAF accuracy, HCC capture rate, and quality measure performance.

**Execution Targets**

- 70% of total cohort visits completed by Day 90
- 85% in-network referral completion rate
- Documented average RAF increase from baseline
- Early PMPM flattening signals visible in target cohort data
- Next wave expansion cohort identified and outreach initiated

# Section 7: Executive Performance Dashboard

The following metrics define the performance monitoring framework for the 90-day sprint and ongoing operations. Review weekly by operational teams, monthly by physician and executive leadership.

> **Cohort Definition**
> 500 patients | RAF < 0.8 | PMPM > $1,000 | No PCP visit in 6 months | No AWV this calendar year | Not enrolled in CCM or TOC | Excluding ESRD and active oncology

## Attribution and AWV

| Metric | Target | Frequency |
|---|---|---|
| AWV completion rate | > 70% by Day 60 | Weekly |
| PCP E/M completion rate | > 80% by Day 90 | Weekly |
| Portal enrollment rate | 100% of scheduled patients | Ongoing |
| 3rd next available appointment | < 5 days | Weekly |

## RAF Lift

| Metric | Target | Frequency |
|---|---|---|
| Baseline average RAF | Documented at Day 1 | Once |
| Net RAF change | Positive lift by Day 60 | Monthly |
| % with ≥1 HCC recaptured | > 80% | Monthly |
| % with new HCC captured | Track by provider | Monthly |
| Projected annual revenue impact | Calculate RAF lift × $10–12K per point | Monthly |

## Care Management and Leakage

| Metric | Target | Frequency |
|---|---|---|
| CCM enrollment rate | > 40% of eligible by Day 60 | Monthly |
| TCM enrollment rate | 100% of eligible discharged patients | Weekly |
| In-network referral completion | > 85% by Day 90 | Weekly |
| Endocrinology / cardiology redirection | > 75% by Day 60 | Monthly |
| Referral external rate | < 15% | Weekly |

### MLR Stabilization

| Metric | Target | Frequency |
|---|---|---|
| Baseline PMPM | Documented at Day 1 | Once |
| Current PMPM trend | Measurable flattening by Day 90 | Monthly |
| ED utilization rate | Downward trend by Day 90 | Monthly |
| 30-day readmission rate | Downward trend by Day 90 | Monthly |
| BH follow-up within 30 days | > 60% | Monthly |

## Closing Perspective: A Unified Operating Model

Value-based care is not built through dashboards, episodic initiatives, or compliance presentations. It is built through compassionate, disciplined execution where clinical teams proactively prepare for the patient before the visit, coordinate care across one integrated EMR, close gaps in quality and medication adherence, document patient acuity and social determinants with accuracy, reduce outmigration, and surround patients with navigators and care teams who make them feel known, supported, and continuously connected to the system. The organizations that succeed are the ones that operationalize compassion, continuity, accountability, and clinical integration into the daily workflow of care.

| Operational Lever | What It Controls | Financial Impact |
|---|---|---|
| Attribution | Whether a patient's spend is counted against the practice's risk pool | Lost attribution = lost RAF revenue and quality exclusion |
| RAF accuracy | Whether the practice receives risk-adjusted payment commensurate with complexity | Every 0.1 RAF point = ~$1,000 annual revenue per patient |
| Care management enrollment | Whether high-risk patients have structured monthly oversight | CCM revenue + reduced ED and readmission utilization |
| Referral direction | Whether specialty care is completed inside or outside the network | External referral = leakage of diagnostic and procedural revenue |
| Quality performance | Whether HEDIS and Star Rating gaps are closed | Quality bonuses, MA contract positioning, shared savings |
| Scheduling access | Whether patients can reach care within 14 days | Out-migration, duplicate testing, downstream revenue loss |

**The Bottom Line**

Accurate RAF capture, attribution retention, and specialty leakage control are not separate initiatives. They are the same operational discipline executed consistently at the point of care. When this framework is implemented correctly, it does not ask physicians to work harder. It ensures they are paid correctly for the work they already do, their patients receive coordinated care, and the organization builds a financially sustainable model that rewards quality and longitudinal relationships.

**Disclaimer:** The information, operational strategies, workflows, benchmarks, and observations presented are derived from historical workstreams, operational experience, and transformation initiatives across hospital systems, clinically integrated networks, medical groups, specialty practices, ambulatory operations, and value-based care environments. This material is intended for educational, strategic, and operational discussion purposes only and should not be interpreted as legal, coding, reimbursement, compliance, financial, or clinical advice.

Healthcare organizations, providers, and leadership teams should always consult current federal and state legislation, CMS guidance, payer policies, compliance standards, proper coding and documentation requirements, and clinical leadership before implementing operational, financial, or care management strategies. All patient care decisions should be guided by physician and clinician judgment, evidence-based medicine, compassion, continuity of care, and the unique clinical and social determinants of health (SDoH) impacting each patient.

The overarching goal of these operational concepts is to support clinically integrated, patient-centered care models that improve access, coordination, outcomes, sustainability, and the overall patient experience.

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