SCAFP Summer Break Away and Annual Assembly

Population Health Management 2026: More Than Just Seeing Patients

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Objectives

- Define Population Health Management through the ambulatory lens
- Understand the most recent ambulatory quality measures where attention is needed
- State strategies needed for your practice to succeed on quality benchmarks

What is “population health management”

- Population Health Management (PHM) in primary care refers to a systematic approach to ensure that all members of a defined patient population — not just those who actively seek care — receive appropriate preventive, chronic, and transitional care
  - Overarching goal of care: keeping the population as healthy as possible, while minimizing costly, inappropriate utilization (“waste”) with delivery of this in a way to engage the patient base to follow the clinical lead of the attributed physician.

What is "population health management"

- You are the CMO of a Health Plan with 15,000 members. You are asked to revamp the Plan, and you are given a clean slate to devise a "successful population health management strategy" following the overarching goal above.
  - Keep population healthy….minimize cost ….. and have an engaging and happy patient base… (triple aim) … the Health Plan commits to be amenable to physicians' needs to strive for an engaged and positive physician base (quadruple aim).
- As we revamp/build our own plan, this can give us insight on what we see affecting us in practice

Keep population as healthy as possible…from what?

- Where are our pain points regarding clinical areas of cost?
  - Five most expensive diseases account for over 80% of all direct health care spending.
    1) Heart Disease: $194 billion. Mortality rate of heart disease has been cut by half in the past 30 years, in large part due to coronary bypass surgery, Prevention is the best mode of control and treating risk factors (HTN, hyperlipidemia, and diabetes) its hopeful the positive trends will continue
    2) Diabetes: $176 billion. It is linked to heart disease and kidney disease (thus, called a "*gateway disease*") as well as nerve damage and high BP.
    3) Dementia: $159 billion. Quickly growing and expected to double by 2040. Greatest economic costs of dementia are related to institutional and home-based long-term care. Over 75% of costs are related to formal/informal home-based care
    4) Cancer: $157 billion: The American Cancer Society (ACS) argues that with dietary changes, increased physical activity and additional screening, roughly two-thirds of all cancer deaths might be prevented – cancer is. Linked to smoking, drinking, a high-fat diet, not enough physical activity, etc.
    5) Obesity: $147 billion: Currently, 66.3% of Americans considered obese or overweight.
  - [2]Outpt/Ambulatory spend > hospital spend (42.2% vs 23.8% - the rest is dental , ED, home health, etc.), but OP is growing faster and hospital cost/visit is much greater

[1]Fast Facts: Health and Economic Costs of Chronic Conditions. CDC Chronic Disease (AUG. 8, 2025); [2]JAMA. 2020. Dieleman, JL,, Cao J, Chapin A, ,et al.

There are a lot of numbers on that last slide ….

- AND FOR POP HEALTH MGMT, DATA IS KING!!!
- You will need to use your (or an affiliate's) EMR to
  - Run reports to find opportunities for quality gap closure
  - Help engage patients through outreach efforts
  - Coordinate care (hosp. follow-up., ED visits, refer to subspecialists, etc.)
  - Share data with affiliates, etc.
  - Dashboard support your providers and clinical teams

Getting to those who need "management"

- We need to get down to specific *patients* (vs. *conditions*) who need us the most as some patients may have varied degrees of several conditions
- Risk stratification allows us to "make visible" patients who need our attention first
  - All conditions are included that affect the population at large's cost of care
- The risk stratification score will be applied by linking it to disease states, with the higher clinical weight being linked to the more impactful condition, thus getting it more visibility – in a hierarchy of severity – called a hierarchical condition category (HCC)

https://pmc.ncbi.nlm.nih.gov/articles/PMC5517668/nih.
https://link.springer.com/article/10.1186/s12875-025-02923-wspringer.

Documentation…Diagnosis…Clinical Weight

- Since 2004, HCCs have been used by the Centers for Medicare and Medicaid Services (CMS) as part of a risk-adjustment model that identifies individuals with serious acute or chronic conditions.[1]
- And …. People change each year, so documentation must follow the change via redocumenting and updating our documentation so we can "show our work" and capture the patient's full clinical picture.
  - HTN w IIIa CKD and BMI 37 w A1c of 5.9 can become HTN w stage IV CKD and a BMI of 39 and A1c of 6.4 and IGT – documentation capture on claims we submit on our patients (we all have a population risk score)
- And … and quality is tied to the "weight" (*tied to our disease diagnoses*)

[1] https://www.Wolterskluwer.com

Documentation…Diagnosis…Clinical Weight…Money?

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- And … and quality is tied to the "weight" (*tied to our disease diagnoses*)

  … and **$$$** is tied to the "weight" → more money for more complex

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Risk Adjustment Calculation

- Average patient of average health — RAF = 1.0
- Healthy patient — RAF < 1.0
- Patient with multiple illnesses — RAF > 1.0

CMS (insurance company "X") applies a base rate to each health plan for managing a patient for this calendar year…

- $10,000/risk score of 1.0*

*for illustration only

Specify Disease State: CKD

- Avoid "Chronic Kidney Disease, unspecified" if stage is known
- Chronic Kidney Disease is defined as
  - Kidney damage: pathologic abnormalities or markers of damage, including blood/urine tests (microalbumin-sensitive dipstick), or imaging studies
  - *GFR: At least 2 eGFRs < 60 cc/min for > 3 months OR* ***albumin/Cr > 30mg/g*****

Stage I	normal,	eGFR > 90ml/min		N18.1
Stage II	mild,	eGFR 60-89ml/min		N18.2
*Stage III**	*mod*	*eGFR 30-59 ml/min*	*+.127**	N18.30 or N18.31 or N18.32
Stage IV	*severe*	*eGFR 15-29 ml/min*	*+.514*	N18.4
Stage V	*kid. failure with eGFR < 15 ml/min*		*+.815*	N18.5 (ESRD 18.6, Z99.2 dialysis)

** 2019*

**recommended method to assess albuminuria

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- Prove stability before assigning condition
- Add ICD10 Dx code to problem list
- Educate patients as to the "why"
- If comorbid, add to base code
- Reassess each year to insure correct

** 2019*

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"HCC Math w Disease Interactions"

69 yo with HTN, Stage IIIb CKD and unspecified heart failure:

- Hypertension (I10.) 0.000
- (Hypertension) Kidney Disease, Stage IIIb
  - Hypertensive Chronic Kidney Disease (I12.9) 0.000
  - Chronic Kidney Disease, Stage IIIb (N18.32) 0.127
- Heart Failure, unspecified (I50.9) (HF risk score is same) 0.360

subtotal …….. **0.487**

Disease interaction between HF and CKD +0.176

TOTAL HCC **0.663**

The combination of the heart failure and the chronic kidney disease evaluated in the same encounter is seen as a comorbid disease interaction and adds HCC risk to the encounter. *No additional ICD 10 diagnoses are required* as the combination of the two diseases in the same encounter automatically adds the *disease interaction HCC weight*.

--With the HTN CKD impact, disease risk is realized (0.127) PLUS a disease interaction of (0.176) w/ HF.
--Without CKDIII ….only HTN (risk score of 0). HF still risk adjusts (0.360) but no credit for the CDKIII or the disease interaction between CKDIII and HF..

As documented, the financial allotment: $6,630
Without the CKD (and the dz interaction) $3,600

Disease Interaction "HCC Math"

Disease interactions

- Heart Failure and kidney 0.176
- Heart Failure and Diabetes 0.112
- Heart Failure and chronic lung disorder 0.078
- Heart Failure and specified heart arrhythmias 0.077
- Chronic lung disorder and cardiorespiratory failure 0.254
- Substance Disorder and psychiatric 0.087

Heart Failure – affects multiple conditions in patients

Make sure to assess/manage HF at every encounter that it is present in your patients!

Once we know who…then what?

- The patients with a higher HCC score often have multiple conditions in to be addressed.
  - Risk stratify by going to the highest score patients to manage

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2026 Stars/ACO Quality Metrics (11.2025)

Measure	Program		Star Category & Weight		Thresholds 09/25/2025	
	Stars	eCQM MSSP	Part C or D?	Weight	4 Star	5 Star
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Concurrent Use of Opioids and Benzodiazepines*	✓		D	1	13%	8%
Polypharmacy: Use of Multiple Anticholinergic Medications in Older Adults*	✓		D	1	8%	5%

Once we know who…then what?

- The patients with a higher HCC score often have multiple conditions in to be addressed.
- Where to start? TRIPLE WEIGHTED condition patients with high HCC

The Stars Quality "Success"

- Medicare Advantage is the main player here, but Traditional Medicare also uses HCCs. The contracts between CMS and the respective MA plans sets the bar for us
- The ultimate "win" is when the outcomes surpass the "4 Star" threshold. Plans get an economic bonus at this level. Accordingly, providers also see some economic benefit for attaining this benchmark. Clinically, our population appears well managed (our goal) at the 4-star level.
- Due to the number of measures, the focus is on the more heavily weighted ones (triple weighted). Those measures usually are high cost
- Each year, CMS(insurers) increases the thresholds. Graded with our peers

The Stars Quality "Success"

- The Triple Weighted Measures (there are six…)
  - BP Control
  - DM Control
  - Medication Adherence: BP, DM, Statins (lipid)
  - Readmissions (30d)

The Stars Quality "Success"

- The Triple Weighted Measures
  - **BP Control**: Percentage of patients 18-85 w/ HTN with BP <140/<90 (both need to be below).
    - The last BP of the year is measured in quality reports
    - All encounters count – except ED, hospital care. Hospice.
    - Office visits, patient reported (validated device), video visits. CPT II code submission may automate – but valid numbers need to be captured
    - End of Year Push to retake all BPs that are out of range in December to try to capture by EOYr.

The Stars Quality "Success"

- The Triple Weighted Measures
  - **DM Control**: Percentage of patients 18-75 w/ DM with A1c<9. The last A1c of the year is measured in quality reports
    - A1c (83036) is now approved for screening w/o co-insurance (Z13.1) for DM. Use "-TS" if patient has pre-diabetes. For DM, can check A1c q6m if stable, q3m if not at goal. Use the code for "DM w **hyperglycemia**" E11.**65** (DMII w **hyperglycemia**) and E10.**65** (DM I with **hyperglycemia**) or E08.**65** (DM from underlying condition with **hyperglycemia**.)

xxx.65 is the "hyperglycemia" dx code

Where to focus our efforts? Stars Single Weighted

- **Diabetic Eye Exams**
- Statin Use in Persons with Diabetes
- Diabetic Kidney Disease Monitoring (new in 2023, Stars 2025)

Diabetes Dilated Retinal Eye Exam

- Percentage of patients 18-75 years of age with diabetes with a visit during the measurement period.
- The percentage of Diabetic patients aged 18-75 with/without a diagnosis of retinopathy who had a retinal or dilated eye exam by an eye care professional during the measurement period (or 12 months prior)

Where to focus our efforts? Stars Single Weighted

- Diabetic Eye Exams
- **Statin Use in Persons with Diabetes**
- Diabetic Kidney Disease Monitoring (new in 2023, Stars 2025)

Statin USE in Persons with Diabetes

- Not **adherence** – this is **USE**
- Adults aged 40-75 years with a diagnosis of diabetes
  - Two Rx fills for a hypoglycemic agent during the year puts you IN this measure (insulin IS counted in this, but not a stand-alone SGLT2i)
  - You pass if you fill *ONE Rx of a statin* during the year *(not 80%)*
- Excluded if in hospice or ESRD or myopathy/myositis/rhabdo claim in calendar year

Where to focus our efforts? Stars Single Weighted

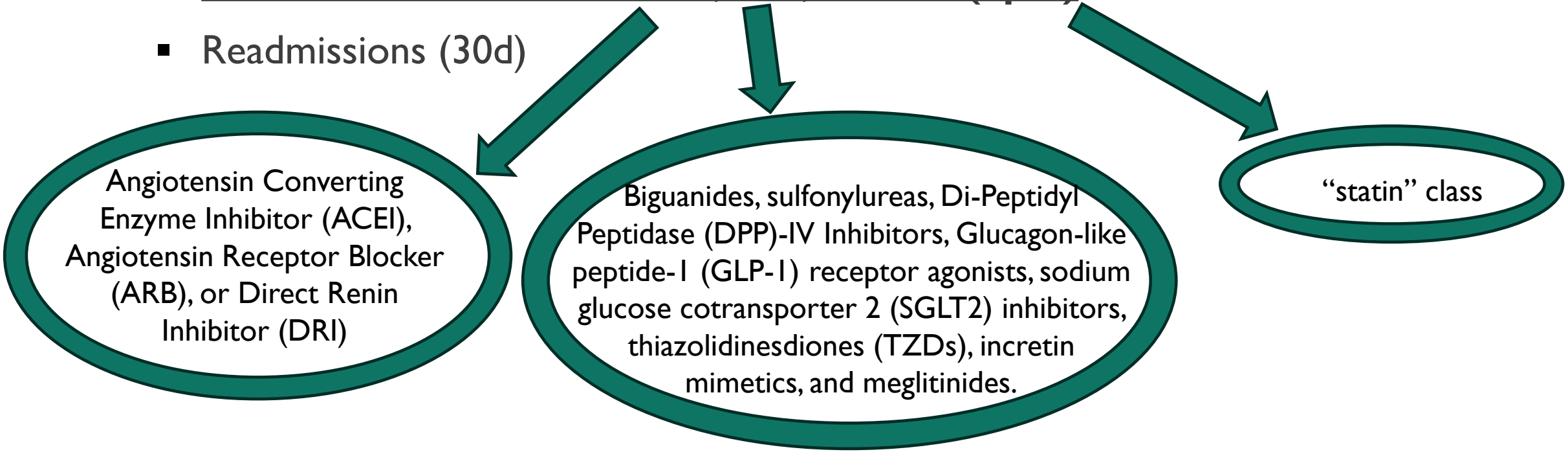
- Diabetic Eye Exams
- Statin Use in Persons with Diabetes
- **Diabetic Kidney Disease Monitoring**
  - **Since 2023, Stars in 2025**

Diabetes Kidney Disease Monitoring

- Former Comprehensive Diabetes Care measure is retired
- Replaced by Kidney Health Evaluation for Patients w DM ("KED")
  - If 18-85 at end of the year with DM in current or prior year, or medication for blood sugar control filled
  - Need BOTH done EACH year
    - uACR is the urine albumin-creatinine ratio
    - eGFR is the estimated glomerular filtration rate
  - Excluded if in hospice, palliative care, or ESRD. If > 66 with long-term institutional facility and/or frailty and advanced illness. 81 or older w frailty.

The Stars Quality "Success"

- The Triple Weighted Measures
  - BP Control
  - DM Control
  - **Medication Adherence: BP, DM, Statins (lipid)** = 80% of the time
  - Readmissions (30d)



The Stars Quality "Success"

- The Triple Weighted Measures (there are six…)
  - BP Control
  - DM Control
  - Medication Adherence: BP, DM, Statins (lipid):
  - Readmissions (30d): Fully deploy Transitional Care Management (TCM)
    - All inpatient or observation hospital care
    - Call the patient within TWO **business days** of discharge for a clinical follow-up and to set up the appointment to see provider withing SEVEN (best practice) **calendar days** for a high MDM (99496) or a low MDM (99495) complexity visit or within FOURTEEN calendar days for a Moderate MDM complexity visit.

Transitional Care Management (MDM Based on 2 of 3 Components)

E/M LEVEL, MDM	NUMBER AND COMPLEXITY OF **PROBLEMS** ADDRESSED	AMOUNT AND/OR COMPLEXITY OF **DATA** TO BE REVIEWED AND ANALYZED (Each unique test, order, or doc. reviewed counts)	**RISK** OF COMPLICATIONS, and/or MORBIDITY/MORTALITY OF PATIENT MANAGEMENT
99495 Moderate MDM	MODERATE NUMBER AND COMPLEXITY • One or more chronic illnesses with exacerbation, progression, or treatment of side effects • 2 or more chronic stable illnesses • New prob w/ uncertain prognosis • Acute illness with systemic symptoms • Acute complicated injury	**(Must Meet 1 of 3 Categories: Moderate)** Category 1: Tests, documents, historian (any 3) 1. *Review of prior external note(s) from EACH unique source 2. *Review results of EACH unique test 3. *Order of EACH unique test 4. Assessment requiring an independent historian. ***OR*** Category 2: Independent interpretation of tests • Independent interpretation of tests performed by another provider (not separately billed) ***OR*** Category 3: Discussion of management or test interpretation • Discuss mgmt./interpretation of test with another provider (not separately billed) **(Must Meet 2 of 3 Categories: High)**	Moderate risk of morbidity from additional tests/treatment Consider: • Rx mgmt., • Decision regarding minor surgery w/ patient or procedure risk factors • Decision regarding elective major surgery w/o risk factors • Diagnosis or treatment significantly limited by social determinants of health
99496 High MDM	HIGH NUMBER AND COMPLEXITY • 1 or more chronic illness with severe exacerbation, progression, or treatment side effects • Acute/chronic illness that may pose threat to life or bodily function		High risk of morbidity from additional diagnostic testing or treatment Consider: Drug therapy req. intensive monitoring for toxicity, Decision regarding hospital care (admit/escalate), Decision regarding elective major surgery w/ patient and/or procedure risk factors, Decision to de-escalate care/decide DNR due to poor prog, IV controlled substance use

Other Stars Quality "Successes" Clinical and Cost

- The Triple Weighted Measures (there are six…)
  - BP Control
  - DM Control
  - Medication Adherence: BP, DM, Statins (lipid):
  - Readmissions (30d): Fully deploy Transitional Care Management (TCM)
- Other areas of concern
  - Utilization excess: ED use, hospital admissions

Updates to CMS Stars Measures

- *Colon Ca Screening – age update (45); blood-based biomarkers (Sheild)
- *Breast Cancer Screening – age update (40, q year, baseline at 35-40)
- Combined Use of Opioids and Benzodiazepines
- Multiple Anticholinergic Medication Use in Adults (Polypharmacy)

*MLN006559

Reminder: CMS Polypharmacy Quality Measures

POLYPHARMACY-ANTICHOLINERGIC MEDICATIONS (POLY-ACH)

- Patients ≥ 65 years old
- Concurrent use of 2 or more different anticholinergic medications (specific med list-Beers Criteria)
- Lower rate is better
- Exclusions: Hospice

CONCOMITANT USE OF OPIOIDS & BENZODIAZEPINES (COB)

- Patients ≥ 18 years on chronic opioid
- Overlapping days supply with benzodiazepine
- Lower rate is better
- Exclusions: Cancer, sickle cell, palliative care, hospice

Strategies for Global Success

- Aggressive, intentional chronic conditions focus (Stars chart)
  - DM, HTN, Renal disease, lipid management, Osteoporosis, Depression
  - Visits that are regularly scheduled with the same provider/team had best outcomes and cost of care (optimal at 10 visits/yr)[1]. Risk stratification helps. Team based care.
- Comparative Effectiveness Research overlay in decision making
  - "If 70% of the population is successfully treated with a safe, low-cost drug, then it should be used first line before using the high-cost drug that successfully gets results 95% of the time as long as patient safety/outcomes are not negatively affected".

[1]AMA Internal Medicine. 2015. Hughes DR, Jiang M, Duszak R.

Strategies for Success

- How to engage patients and juggle all this info?
  - Deploy Annual Wellness Visit strategy and get the team's help to succeed
    - Ancillary staff
      - Pre-visit call to cover HRA, ask about immunizations, CA screening, etc.
      - Follow-up after MWV to ensure preventive measures done
      - Some screens are actionable (Depression Screening, Falls Risk, etc.)

MWV Strategy: Is there a financial/clinical reason…?

- Yes, bill for both (ov-25 and MWV) encounters with the MWV part mostly done by staff and you sign-off on that.
  - HRA, Depression screen, Falls Risk, Cognitive Assessment, Medication reconciliation, personalized health maintenance advice
- Beckman, et al. in American Journal of Managed Care (03.2019)
  - Patients had substantially more falls risk screens than non AWV pts
  - Higher A1c control rate was noted
  - Higher percentage of patients offered guideline-directed medical therapy
  - Had a decreased total cost of care of 5.7% (esp in the patients with the highest HCC scores) – yearly savings outpaced the fees generated to primary care (most savings from hospital-linked care).

Second…MWV Compliance …. What about the audits….?

- During the COVID pandemic, probe and educate audits were paused
  - Probe and Educate (P/E) audits restarted 03/2024. Expectations to find in note:
    - Medications and supplements used, List of providers/suppliers, Cognitive Assessment, Depression Screening, Functional Assessment, Screening schedule for beneficiary, Risk factor assessment, Counseling programs. For subsequent AWV notation that medical/family history and health risk assessment were reviewed and updated, if needed. Copy of any ABNs and appropriate signatures
  - AAFP did a review with its National Research Network 06/30/2022 (from 03/2019) in 36 states, 145 practices: results showed that *~85% of MWV may be done wrong*
- What about any national outcomes…..

Penn State Health agreed to pay >$11M to resolve improper billing allegations to CMS for MWV services (02/07/2024)

https://www.cgsmedicare.com/partb/mr/activity_log.html

Successful Strategies beyond MWV

- Expand your clinical footprint by expanding your team, access to care. Team-based care outperforms solo regardless of the profession. Limits burnout.
  - Adding NPs/PAs, but watch the quality/cost -- Hattiesburg, etc.[1]

  But….
  - Evidence is fluid and pockets may emerge where provider types are immaterial (Health Affairs, March 2021 40:3) – but clear especially in the "pre-diagnosis" settings that physician-led care is still goal standard.
- Standardize your process and own the clinical outcomes of your practice
  - Cadence with communication with APPs re quality (dashboards)
  - Dashboard review monthly - as end of year approaches deploy clinical outreach (BP, A1c, etc.)
- ***Be open minded and do your own internal research***
  - Team-based care still seems to outperform all models[2]
  - Deploying physician-led team-based care management models aids in quality and lessens burnout

[1] Targeting Value-based Care with Physician-led Care Teams, *Journal of Mississippi State Medical Association*
[2] *Health Affairs 40:3. pp435-444*

Population Health Management: Ambulatory Focus

Advanced Primary Care Mgmt Services: Care for patients with chronic conditions expected to last 12 months (or until death). Provided by clinical staff under physician (or other qualified health professional - QHP) who is focal point of care delivery. Per month. No time interval. Consent is needed (verbal OK).

- G0556 (wRVU 0.25/$15.20): one chronic condition
- G0557 (wRVU 0.77/$48.84): two or more …
- G0558 (wRVU 1.67/$107.07): two or more in a dual eligible Medicare pt.

Think "CCM" without the time interval. Service delivery is required but not each month….need a visit to set up (no specific code), 24/7 access, enhanced options (e-visits, etc.), qualified EHR, risk stratification and population health strategies (think ACO-type care). Permission up front as not "free" *unless you are dual eligible* (**G0558**). NO "duplicate" service billing same month: TCM, CCM/PCM, etc.

Closing

- Population Health Management is more than just seeing patients
- A successful population health management strategy includes
  - Know your attributed patient base and risk-stratify them
    - Capture chronic conditions correctly and use this data to target management
  - Know how to successfully manage the conditions this population possesses
    - Chronic disease management thresholds (Stars chart - beat the 4-star measure)
  - Use team-based tools to excel in care delivery
    - Focus efforts on Annual Wellness Visits and Preventive Medicine/Health Maintenance
    - Delegate outreach efforts and get team to aid in data capture, quality outcomes management
  - Use care management strategies (APCM, etc.) to offload tasks and improve outcomes… in the context of a physician-led, team-based model.

THANKS for being a part of this session!! For Questions, reach out ….

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E/M LEVEL, MDM	NUMBER AND COMPLEXITY OF **PROBLEMS** ADDRESSED	AMOUNT AND/OR COMPLEXITY OF **DATA** TO BE REVIEWED AND ANALYZED (Each unique test, order, or doc. reviewed counts)	**RISK** OF COMPLICATIONS, and/or MORBIDITY/MORTALITY OF PATIENT MANAGEMENT
99495 Moderate MDM	MODERATE NUMBER AND COMPLEXITY • One or more chronic illnesses with exacerbation, progression, or treatment of side effects • 2 or more chronic stable illnesses • New prob w/ uncertain prognosis • Acute illness with systemic symptoms • Acute complicated injury	**(Must Meet 1 of 3 Categories: Moderate)** Category 1: Tests, documents, historian (any 3) 1. *Review of prior external note(s) from EACH unique source 2. *Review results of EACH unique test 3. *Order of EACH unique test 4. Assessment requiring an independent historian. ***OR*** Category 2: Independent interpretation of tests • Independent interpretation of tests performed by another provider (not separately billed) ***OR*** Category 3: Discussion of management or test interpretation • Discuss mgmt./interpretation of test with another provider (not separately billed) **(Must Meet 2 of 3 Categories: High)**	Moderate risk of morbidity from additional tests/treatment Consider: • Rx mgmt., • Decision regarding minor surgery w/ patient or procedure risk factors • Decision regarding elective major surgery w/o risk factors • Diagnosis or treatment significantly limited by social determinants of health
99496 High MDM	HIGH NUMBER AND COMPLEXITY • 1 or more chronic illness with severe exacerbation, progression, or treatment side effects • Acute/chronic illness that may pose threat to life or bodily function		High risk of morbidity from additional diagnostic testing or treatment Consider: Drug therapy req. intensive monitoring for toxicity, Decision regarding hospital care (admit/escalate), Decision regarding elective major surgery w/ patient and/or procedure risk factors, Decision to de-escalate care/decide DNR due to poor prog, IV controlled substance use